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American CHILD HEALTH *Association*

FORMERLY AMERICAN CHILD HYGIENE ASSOCIATION AND
CHILD HEALTH ORGANIZATION OF AMERICA

TRANSACTIONS OF THE SECOND
ANNUAL MEETING

KANSAS CITY, MISSOURI
OCTOBER 14, 15, 16, 1924

OFFICE OF THE ASSOCIATION
370 SEVENTH AVENUE, NEW YORK CITY

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TABLE OF CONTENTS

PAGE

For detailed lists of speakers and subjects, see pages 1, 35, 55, 67, 83, 95,
109, 137, 169, 195, 229, 251, and 391.

General Session	1
Presidential Message	3
Opening Address	5
Executive Committee Report	7
Comptroller's Financial Statement	8
Second Annual Report of the General Executive	9
Training Leaders for Child Health Work	35
Group Discussion—Nurses, Community Organizers, Teachers	55
Joint Meeting with Kansas City Annual Fall Clinical Conference and Medical Association of the Southwest—Public Health Program	95
Problems of Late Childhood and Early Adolescence	109
Essentials of Community Organization for Child Health Work	137
Radio Talk: America's Greatest Asset—Her Children	165
Discussion of Some Special Aspects of Child Health Work	169
Essentials of Community Organization for Child Health Work (continued)	195
Joint Session on Pediatrics and Obstetrics with Kansas City Clinical Society....	251
Reports of Affiliated Societies	277
Second Annual Meeting—Business Session	393
Officers, Directors and Staff	395
Resolutions	396
Kansas City Local Committee	397
Index	399

GENERAL SESSION

PRESIDENTIAL MESSAGE

HONORABLE HERBERT HOOVER

OPENING ADDRESS

THOMAS D. WOOD, M.D., Third Vice-President

REPORTS

Executive Committee

Comptroller's Financial Statement

General Executive, Mr. Courtenay Dinwiddie

PRESIDENTIAL MESSAGE

HONORABLE HERBERT HOOVER

“TO THE AMERICAN CHILD HEALTH ASSOCIATION:

“I deeply regret that I shall not be able this year to open the annual sessions of the Association, but important duties have made this impossible. The work of the Association during the past year will be laid before you and I know will meet with your approval. This year has been one of great accomplishments and great growth in the work of the Association. It is finding itself by extending cooperation with all of the forces in America making for fundamental progress in the protection and development of our children. It is only through continued voluntary cooperation of all these forces that we can accomplish the stupendous task which lies before the Association.

“I wish to convey my heart-felt obligation for the fine support we have had during the past year and my wishes for a successful session and for your continued cooperation in the year to come.

“(Signed) HERBERT HOOVER.”

Washington, D. C.,
October 14, 1924.

OPENING ADDRESS

THOMAS D. WOOD, M.D., Professor of Physical Education, Columbia University

Our convention, at least the meeting this morning, is in a very real sense like the play of Hamlet with Hamlet left out, as Mr. Hoover is unable to be present. We regret this more than we can say. I am glad to read this telegram from Mr. Hoover, President of the Association.

The American Child Health Association stands for the promotion of the health of EVERY CHILD in America as essential for the conservation of the most valuable of all of our national resources. (I have taken the liberty of writing "EVERY CHILD" in capital initials to make this as really concrete as possible in the minds of all of us.) I wish that you might all have had the opportunity, the privilege of reading the poem entitled "Every Child" by Dr. Frederick Peterson, Chairman of the Committee on Health Education of the American Child Health Association, and one of the original members of the Child Health organization.

My second suggestion is:

The American Child Health Association stands for the advancement of the health of all the children of mankind as the fundamental safeguard of civilization.

I should like to refer more in detail to what Mr. Hoover has stated with reference to this program of accomplishment during the past year in the work of the Association. I should like to call your attention very briefly to certain dangers which the American Child Health Association, through its policy and work conducted by its staff under the guidance of President Hoover and the Executive Committee, has tried to avoid and which we believe in some essential and striking results it has given evidence of avoiding.

There is first the failure to recognize the importance of the position and functions of official and governmental agencies. The Association has tried to recognize this danger, which has occurred in the past not infrequently in voluntary organizations and among people earnestly interested in human welfare and the various phases of it. We have evidence of the solution of this problem involving the avoidance of this particular danger in the cooperation of the Association with the official health officers of the country, of the states and cities as well as of the federal government. This is illustrated again in the cooperation with the educational superintendents of schools and commissioners of education in the various states and also cooperation with such organizations as the Public Health Association in the effective work which has been

inaugurated and carried on in joint program involving cooperation with that organization.

Another failure which has sometimes been made is the failure of such an organization as the American Child Health Association to evaluate, to appraise its own organization with reference to the efficiency of its methods and the importance or value of the results which it has attained or seems to have accomplished. Provision has been made by the American Child Health Association with reference to this problem or this danger in the institution of a Department of Research, a part of whose functions is to do just this: to try to inventory the results of the Association, the work which is being done and the results accomplished. We are very sure that this department under the effective guidance and leadership of a man trained in research work and public health is giving very genuine and valuable service in trying to meet this problem.

Another danger of voluntary organizations frequently demonstrated is the tendency to perpetuate various projects inaugurated. One of the great fundamentals, perhaps the main opportunity and value of the proposition, is to blaze new trails, to bring to light unrecognized and important facts and principals with reference to human progress, to go ahead of official agencies in calling attention to important new steps to be taken, to make demonstrations by experiment and by the support of experiments; to convince people that new steps are not only theoretically desirable but practicable, feasible. The Association feels that some evidence has been given that when these projects have been brought to the recognition of people or official agencies that it has definitely shown its willingness, its desire to drop these problems, these projects after they have been inaugurated, when other agencies will take them up.

I am calling attention, therefore, to this as an important principle which finds some actual accomplishment and registered results. Almost every effort of the Association during the past year has been taken over or is being taken over by local, official, established agencies.

The Association feels a deep appreciation of the confidence which has been expressed in it and manifested in relation to it by the Foundations that have given support to it, by individuals who have in various ways expressed on paper, verbally and by financial support, confidence in the work which the Association was trying to do, and deep appreciation is felt of the confidence expressed by organizations and agencies which are in such great numbers asking for the cooperation, the help and support of the American Child Health Association in the work which they are trying to do.

REPORT OF EXECUTIVE COMMITTEE AND COMPTROLLER

Philip Van Ingen, M.D., Secretary of the American Child Health Association.

Ladies and Gentlemen: I am very sorry that I must be the one to present this report to you. I think we can all be proud of the results of the work done by our working staff which the Executive Committee reports.

The Association has finished its second year. It is now in the pre-school age, and as you all know every pre-school child requires very careful supervision of its habits, its nourishment, its activities, and so this child of ours, this American Child Health Association, needs that same supervision. The Association has expanded from two organizations with a joint budget of less than one hundred thousand dollars to one spending five hundred thousand dollars in the year. I think you will all realize that means a big responsibility. The responsibility of watching the expenditure of that money has fallen upon the Executive Committee and the President of the Association. Mr. Hoover has been able to secure for us the sinews of war. It has been through his efforts largely that our funds have been accumulated.

Demands for help, advice and assistance of all kinds which have come to us from all over the country have simply swamped us and the Association has had to adopt some definite plan for carrying on the work. Mr. Hoover appointed a committee to study our activities and financial support. That committee spent about ten days, almost continuously, during the hot summer months working out policies and plans. You have seen them, or had an opportunity to see them as they have been published through our magazine.*

The Executive Committee has approved the plan of work as submitted. It has also recommended to the incoming Board of Directors that there be some changes in our method of organization. It is a very difficult job for the Association to raise through Mr. Hoover's help the amount of money we need and we must have an organization that is so constructed that the people are going to be confident it is

* Child Health Magazine, July, 1924.

organized on a sound business basis. For that reason a number of changes in our by-laws will be proposed during this year.

The Board of Directors have approved the recommendation of the Executive Committee that the paid personnel in Washington be discontinued. That is on the grounds of economy. We will have a representative there but not a working office.

The Association has been requested by the National Health Council, composed of some sixteen different national health organizations, to join with them in a conference which it is proposed to hold in 1926, and the Executive Committee has recommended that the Association take part in such a conference, which it is hoped will be international in character. The recommendation will be submitted to the Association for action at the closing meeting of the Association.

I should like to say, as Secretary of the Association and as a member of the Executive Committee, that the Association, in my opinion, has been well served by their Board of Directors and has been most faithfully and unselfishly served by their officers and by their Executive Committee.

FINANCIAL REPORT

The Secretary then presented the following financial report, in the absence of Mr. Flish, the Comptroller:

Cash Balance, January 1, 1924.....	\$ 7,072.25
Receipts, January 1 to September 30, 1924...\$360,588.59	
Estimated Receipts, October 1 to December 30, 1924	121,142.87 481,731.46
	\$488,803.71
Expenditures, January 1 to September 30, 1924	\$370,115.40
Estimated Expenditures, October 1 to December 31, 1924	106,500.00 \$476,615.40
Estimated Balance for the year.....	\$ 12,188.31

PROGRESS IN CHILD HEALTH

Second Annual Report to the Directors of the American Child Health Association,
COURTENAY DINWIDDIE, General Executive

The trend of events can be seen in proper perspective only when we look back over a period of some years. Such a review shows us that during the past few decades the picture of the child as the future citizen has greatly changed. It has been painted from time to time, in brilliant colors but with hazy details, by those who wished to play upon our emotions. Some have used it to separate us from our dollars for relief projects which often did the child more harm than good. Others have used it to convince us of the vital importance of voting for or against some political nostrum in order to save the children, and therefore the nation, from disaster.

Our progress toward transforming this vague image, which would justify almost any emotional response, into a clear mental picture which moves us to intelligent action, is best seen in the evolution of our attitude toward education. A century ago the man who proposed to expend any such percentage of our public funds as we devote today to universal child education would have been branded as a dangerous visionary.

We are facing just the same uphill struggle when we attempt to bring about a concrete conception of child health, not as a flower of the field that just grows, but as a distinct product of healthful inheritance, healthful environment, and education in healthful living. As compared to protection of property from fire and theft, the protection of the health is still of minor importance in the eyes of our appropriating bodies.

Even recently, a professional man, speaking before a national convention, took the position that it was almost immoral to ask a community to spend more than 50 cents per capita for public health work, although our national citizenship in 1919 expended \$7.67 per capita for confectionery and \$17.36 for tobacco.

It is refreshing, in the face of such inertia and lack of clear thinking, to note the general and substantial progress toward a public appreciation of definite, constructive measures for the protection of childhood. Growth in understanding is being followed by a genuine sense of responsibility on the part of officials and citizens. Tangible evidence of this is found in larger appropriations for the control of disease, for physical and health education in the schools, and improvement of living conditions.

The response to the appeal that May Day should be set apart as a day for emphasizing the vital importance of child health to the nation

was remarkable testimony to the interest of the average citizen. In 38 states state chairmen for May Day were appointed. Of the Governors, 25 approved the plan officially, 21 issuing proclamations in support of it. It would be impossible to list the thousands of organizations which observed the day. Papers containing editorial publicity, not counting news items, had a total circulation of 12,000,000. The most significant result was the wide demand for definite community programs for child health, using May Day only to center interest on the subject.

Other gratifying indications of aroused public interest have been the welcome accorded the five men who surveyed child health conditions in 86 medium sized cities during the year; the almost immediate follow-up by the public authorities of the local work undertaken by this Association in various states for purposes of demonstration; the acceptance by 41 states and Hawaii of provisions of the Sheppard-Towner Act, making over \$847,000.00 of Federal funds available for infancy and maternity work; the issuing of a comprehensive report on health education by the Joint Committee of the National Education Association and the American Medical Association, illustrating the increased interest of these groups in this subject.

It is still true that the most exact bases we have for appraising the state of the health of our children and our mothers are the infant and maternal mortality rates. With the exception of the year 1918, the influenza year, infant death rates have shown a continuous decline since 1915, when the reports for the Birth Registration Area were first available. The sharp reduction in 1921 has not proved to be temporary, for the rates of 1922 and 1923 have been even slightly better, in spite of a 3 point increase in the 1923 infant mortality rates in the rural areas.

While the maternal mortality rates as a whole are high and have not shown the decline we should wish there is some encouragement in the indicated decrease in deaths from puerperal septicemia.

We are just beginning the process of measuring the health status of individuals in terms other than mortality—that is, in increased resistance to disease, greater vigor, and improved wholesomeness of outlook. Among the 35,000 fifth grade school children whose habits were studied in our survey of 86 medium sized cities, there is encouraging evidence of awakening interest in outdoor play, cleanliness of the teeth and of the body, and in securing a reasonable amount of sleep. But attention to nutrition is evidently needed when 38 per cent drink one or more cups of coffee each day with the consequent decreased consumption of milk; 40 per cent drink less than a pint of milk a day; and only 19 per cent a quart or more. That the importance of milk as a food is necessary to be emphasized was illustrated by the conditions found

in one home. While the milk was entirely absent from the children's diet, a supply of milk was ordered upon the arrival of a new family of puppies.

It was also found that 47 per cent of the fifth grade children referred to had not visited a dentist during the year; and 29 per cent had not been vaccinated against smallpox.

The data that are being built up by such surveys and the examinations of individual children by this Association, governmental bureaus and others are forming a baseline from which to measure future progress in raising the health standards of the individual child.

In addition to the evidence of work ahead for us as revealed in mortality figures and facts as to health habits we find other conditions calling for action. Milk surveys made by this Association in seven states have completely confirmed previous impressions that in thousands of communities children are being exposed to danger through the use of impure and unsafe milk. This was most strikingly illustrated in two instances. One city, which prided itself upon having greatly stimulated the increased consumption of milk, was shown to have a dangerously dirty milk supply. In another case, a state containing several well known health resorts was found to be supplying them with some of the worst milk discovered anywhere by our investigators.

In the survey of the 86 cities referred to above the laboratory control of the milk supply was inadequate in 34. In 12 no inspection of dairies was carried out.

Probably no activity of the Association has so completely lifted the veil from elemental conditions of ignorance, poverty and lack of protection of motherhood and babyhood as the midwifery demonstrations which have been carried on in several Southern communities. When the midwives who are handling the majority of cases of confinement in a county are not only predominantly illiterate but, in many instances, steeped in superstitions, the vital importance of improving this service for the mothers at that crucial time is plain.

No general remarks can reveal the problem more clearly than a statement of a few of the forms of treatment used by these rural midwives. Samples of their treatment to increase labor pains are: "Burn feathers under the nose and rap sharply on the back"; "Make the patient eat a raw, red onion"; "Make her angry." To stop a hemorrhage: "Use tea made out of dirt dobbers' nests, the bark of the simmon tree, and pennyroyal." To prevent night sweats: "Place a pan of water under the bed." Many other equally extraordinary conditions were found.

The great appeal of the rural health problem is realized by any

one who sees not only the difficult conditions of poverty and lack of resources, but the tremendous effort which some of our rural neighbors are ready to put forth to secure information essential to the lives of their babies and older children. One mother was found who with her baby had traveled 130 miles on horseback, camping out over night, in order to be sure to reach an infant clinic.

In the 86 cities surveyed 44 were found to be supporting a prenatal clinic, although the percentage of expectant mothers reached was only eight. This is nowhere near what it should be in communities where the number under adequate supervision by the family physicians is not exceptionally high. The numbers of those receiving medical supervision from their family physicians were not available but they were probably small. In 46 of these cities there were no definite efforts to supervise midwives. It is clear that we have just begun to attack the causes of our high maternal mortality, with which neonatal mortality is so closely bound up.

We have found organized courses of health education in the schools of slightly more than half of the cities observed, although in many instances the methods and standards used need to be greatly improved. In the rural areas visited by our field staff the need for health training of children is even greater and health supervision by physicians, where it exists, is, in most cases, of such a casual nature as to be almost valueless.

When we note that in these 86 cities full-time health officers were found in 45 it is an encouraging indication of progress. But we are sure that the problem of general health and of child health is only beginning to be touched in the other half. Of the 814 cities in the United States having a population of 10,000 or more, only 326 have whole-time health officers, and of the more than 3,000 counties, only 230 have full-time health officers.

While the importance of public health nursing is generally recognized, in at least one-half of the cities surveyed the provision was seriously inadequate, there being only one nurse per 10,000 or more population.

The work done by the American Child Health Association during the past year speaks for itself. Before dealing with individual pieces of work done I wish to mention four outstanding achievements.

First, it has given real stimulus to a national appreciation of child health. It is impossible to appraise exactly the part taken by the Association in increasing the interest and sense of responsibility on the part of the citizens and public officials of the country, but it has undoubtedly made a real contribution, through its May Day program, through work

with civic groups, such as parent-teacher associations, and through cooperation with professional groups such as the health officers, the public health nurses, the grade and special teachers and others.

The survey of the 86 cities of between 40,000 and 70,000 population served as another genuine stimulus to action; the scholarships awarded to teachers in 52 cities had a potent influence through the representative local committees cooperating with the Association in those cities. The enlarged and more attractive Magazine, publicity given to the newspapers and articles contributed to periodicals, unquestionably were great assets in focusing attention upon concrete problems and the necessary steps to solve them.

Second, it has helped to increase local and state responsibility. The number of states and communities to which the Association rendered service which have actually, as a result, set in motion important projects for the promotion and protection of child health is impressive. Such projects range in character from the provision of a travelling laboratory and the regular supervision of the milk supply of a state and the centralization of a community's health activities around a children's clinic, to the organization of a city-wide contest among the schools for the best record in improvement of health habits and health conditions of the child.

In addition, we note very encouraging assumption of responsibility on the part of the demonstration communities for new items of local work, each contributing toward the building of a well developed program for the health not only of the child but of the whole community.

Third, it has made a notable contribution to the measurement of health and health work. The 86 cities survey gives, probably, the most clear and comprehensive picture yet obtained of the actual personnel and organization which our communities are using for the health of their children. The measurements now under way in the demonstration centers should furnish more exact knowledge than we have heretofore had of the actual health status of numbers of children in different parts of the country, on comparable bases. However, the most valuable service which the Association has rendered in this field has been its contribution to the method of appraising community health activities, worked out in cooperation with the Committee on Municipal Health Department Practice of the American Public Health Association and other national agencies and adopted, after revision, by a group of health officers representing 36 cities. For the first time we are able to employ for these cities a scale of measurements, based upon group, not individual judgment, in which the problems of child health are given adequate value and by which cities may proceed to study their strength

and their weaknesses as many are already doing. The increasing interest in this method of studying and improving local work leads us to expect a very great increase in the number of those using it.

Fourth, it has thrown its weight behind real unity of planning and action in the national health field. This has been done through steps of far-reaching importance, taken toward the common handling of the health problems of the country by common standards, in cooperation with other national groups. The close working relationships with the Conference of State and Provincial Health Authorities, by which our Director of Public Health Relations serves as the Field Secretary of their Executive Committee, and with the National Organization for Public Health Nursing, which acts as the Nursing Division of this Association, have been in successful operation for the past year. In addition we have seen the joint development with a committee of the American Public Health Association of the plan for rating community health work, just described. This has led to the immediate proposal of a joint field service bureau under the National Health Council, through which all national health agencies may clear their field work. Also, a very happy coöperation is in effect with the National Tuberculosis Association in many matters of field service relating to health in the schools. It is not too much to say that developments in closer relationship between national public health agencies during the past year have been more striking and important than at any other time in the history of the health movement.

Last year we discussed the program of the American Child Health Association for this year in terms of five main objectives. It might not be amiss to review the accomplishments during this current year in the same terms in order to see how far we have been able to hold to our main purposes.

GENERAL OBJECTIVE I. TO OBTAIN A TRUE PICTURE OF CONDITIONS RELATING TO CHILD HEALTH, NATIONALLY AND LOCALLY, UPON WHICH TO BASE EFFECTIVE ACTION.

The greatest contribution which the Association has made to the accomplishment of this objective has been the child health survey of 86 cities of between 40,000 and 70,000 population (according to the 1920 Census) as proposed by Mr. Hoover last year. The survey was begun on January 16 and concluded on June 19 by five men experienced in the public health field, other members of the Association's staff assisting them. As this survey will be described at length in a later report at this meeting, I shall not attempt to give details here. As

a result of it, we have probably the most comprehensive information as to personnel and equipment for child health work and as to the health habits of children in medium sized cities that has ever been assembled in this country, on nearly comparable bases. The full report is to be issued early in 1925.

It is of much interest to note that the questions asked as to the health habits of children in the survey of the 86 cities showed that the health habits of the children in the schools of Newton, Massachusetts, where such habits have been taught with unusual concentration for several years, were far above the average for the other cities surveyed.

The milk surveys, the birth registration surveys, and the studies of the midwife situation in Southern communities have contributed much to obtaining a true picture of conditions relating to child health. However, because they have so definitely and immediately resulted in the development of local and state programs and organization for effective work, they are presented under General Objective II.

From the facts as to conditions relating to child health which have been revealed by surveys and studies, the Association has been able to contribute substantially to the development of standards and methods of work for conservation in childhood.

The joint preparation of the tentative rating system, just described, by which a city's activities for child health can be measured with due regard to relative values in the whole scale of public health, may prove to be one of the most notable contributions that has yet been made to the public health movement.

An arduous but much needed piece of work has been carried on in cooperation with the Department of Health Education and Psychology of Columbia University for the purpose of preparing workable methods of testing the results of health education in the schools. Eight hundred test questions have been tried out on a group of school children and are now being studied with a view to determining their relative values for this purpose.

At the Health Education Conference held in Cambridge, Massachusetts, in June, much enlightening information as to the actual experience of school health administrators was an introduction to the formulation of some definite and helpful conclusions as to standards and methods in health education from the standpoint of the problems of administrators for both schools and teacher training institutions. The plans for this conference, which was called at the invitation of the Massachusetts Institute of Technology, were developed by this Association in cooperation with the Institute.

Representatives attended from 28 states and two foreign countries and from each of the child health demonstrations under our charge. Over 400 copies of the conclusions reached at the Conference have been distributed, on request, to members of the Conference and to other educational leaders, for use in setting up health education programs this year. An immediate result was the appointment by the American Home Economics Association of a committee to define the place of home economics in health education. This action should influence hundreds of members of that Association. Another result is a projected conference of leaders in the normal school field, to be held under the auspices of this Association and the Joint Committee of the National Education Association and the American Medical Association in Cincinnati in February, 1925.

Methods of health work for pre-school children have been studied in 25 of our largest cities and a report on this work will be published.

GENERAL OBJECTIVE II. WORKING THROUGH STATES AND COMMUNITIES IN BUILDING UP ORGANIZATION AND THE DEVELOPMENT OF LOCAL AND STATE-WIDE PROGRAMS.

As a means of testing the possibilities for following up the survey of the 86 cities, a special visit was made to Michigan by two members of our staff. While the results secured there could not be expected in every state, they were most encouraging. A Michigan Conference of Whole-Time Health Officers was organized to meet quarterly with the State Department of Health for discussion of local health problems, with a view of raising standards of work. These officers requested an appraisal of their activities by the State Department of Health, with the cooperation of this Association. The scoring system, developed since then, has been placed at their disposal.

In addition, the State Departments of Health and Education are jointly carrying out a county demonstration, including health education in the public schools and teacher training in this subject, in the State Normal School in Kalamazoo County.

Advisory service is being given to a number of communities in applying the health scoring system to the improvement of local work.

In contrast to the method of working more exclusively through community and state officials, two other definite attempts are being made, in cooperation with such officials, to work more largely with groups of citizens in an attempt to capitalize the results of the survey of the 86 cities. In each case the state health officials feel the need of awakening the interest of the public in the establishment of the necessary

basic organization for local health department and school health work.

In the first instance, a community organizer is being loaned to one of the larger states, in cooperation with the National Health Council, in an attempt to draw together the community resources in certain selected places for the establishment of full-time health personnel, the lack of which in these places is a serious one. In the second case a worker is being assigned to one of the cities of the South with a view to arousing interest in child health and building toward full-time health personnel.

Milk surveys have been completed in the following seven states: Louisiana, Florida, Kentucky, South Dakota, North Dakota, Delaware, and Michigan. In every state the authorities have at once expressed the intention of establishing a field laboratory to carry on work similar to that done by this Association's survey unit and in two the work is actually under way. The Health Officer of Delaware has been so impressed by the results of the survey in his state that he proposes to go even further and, beginning in October, to carry out a complete study of the whole state rather than just a cross section. In three of these states, two departments responsible for different phases of the milk problem have come together in definite cooperation as a result of the surveys. In Kentucky, the Child Hygiene Bureau has utilized the milk study as a basis for working toward a more complete plan of action for community child health. The State Health Officer informs us that in the communities surveyed and later revised, the ground has been better prepared for the improvement of child health work generally than could have been done in ten years under ordinary circumstances. In Louisiana, eight different dairymen have purchased sterilization outfits, an unusual investment for them. Local laboratory service has been established in three states where the state laboratory was not sufficiently accessible to certain parts of the state, two of these laboratories being in normal schools.

Birth registration studies have been completed in the following seven states: Arkansas, Iowa, New Mexico, North Dakota, Tennessee, South Dakota, and Missouri. This has been done with the hearty cooperation and approval of the State Health Officer in every case. Missouri has already appointed a head of the Division of Vital Statistics as a result, and one of the important cities of the South has appointed a new registrar of vital statistics because of the survey. Arkansas has requested a follow-up study as soon as this can be arranged. In Wyoming, following the publication of the Association's news release on the infant death rate, the Health Officer requested a birth registration survey by the Association.

The midwifery demonstration among 132 colored midwives in Halifax County, Virginia, resulted in the elimination of 30 as unable to profit by instruction; 20 will have to attend additional classes before practicing, and 82 were licensed to practice under close supervision for one year. The procedure and regulations worked out in this county are being used by the State Health Department as a basis for control of the midwives in the entire state. The physicians of Halifax County are enthusiastic about the results secured.

A similar midwifery study in another Southern county will be followed up and the midwives will be supervised by the county nurse. Similar work is now being carried on in several other Southern counties. One of the significant developments of this midwifery work has been the plan of the Health Officer of North Carolina, to carry out, with our cooperation, an intensive application in one of the counties of his state as a basis for strengthening the control of midwifery throughout the state.

For a year this Association has cooperated with the Health Officer of Minnesota in maintaining two Indian Nurses for instructive service to the Chippewa Indians of that state. A scattered Indian population of approximately 3,000 has been influenced so markedly that the health officials and the State Federation of Women's Clubs are greatly impressed by the results and the latter are raising funds to continue the work. A sanatorium for the Indians is to be opened this fall in Minnesota for which the Health Officer gives the credit to this Association. The Health Officer of Wisconsin, from his knowledge of the work in Minnesota, is planning immediately to inaugurate a similar nursing service for the Indians of Wisconsin and has invited us to cooperate in laying out plans.

A request from the Governor of Pennsylvania, that a representative of this Association conduct a survey of the nursing facilities of that state, was referred to the National Health Council and personnel of this Association was loaned to participate in the study of the whole nursing problem of that state rather than child health nursing alone. This study has been completed and the report is in the hands of the Pennsylvania authorities. Many of its recommendations are already in operation.

The study made by this Association in Richmond, Virginia, has borne fruit in the organization and actual operation of a cooperative clinic centering around the health of the child. The City of Richmond raised about \$12,000.00 which was supplemented by a like amount from the Commonwealth Fund to carry out this project. A member of our staff was loaned for the purpose of actually getting the clinic organized.

A public health administrator from the Association's staff, working under the direction of the Louisiana State Board of Health, made an attempt to institute a full-time health unit at Baton Rouge, Louisiana. While the immediate effort to institute a full-time health unit failed, it is believed that the community, as a whole, is in favor of establishing such a unit, and that this may be accomplished in the not distant future.

Similarly a member of our staff assisted the Illinois State Department of Health in a campaign to secure full-time County Health Units in that state. Also help has been given to three state departments of Pennsylvania in a state-wide effort to stimulate intelligent interest in the state's special child health problems and active support of the programs of the governmental bureaus.

The organizer loaned by this Association to the Health Department of Connecticut, completed a period of two months' demonstration of what could be accomplished by organizing community groups in support of child welfare clinics and child health work generally. Advance educational work and stimulation were carried on before a clinic was held in the community, greatly increasing the attendance of mothers and children. In every case the attempt was made to crystallize the interest thus aroused in definite organization for the purpose of following up the babies and children examined and carrying on health work permanently.

No activity of the Association has met a keener or more sympathetic interest on the part of local groups of citizens than its assistance in organizing a state-wide program for the care and education of the crippled children of Maine. A complete program of local and state follow-up outlined by our representative was adopted by the State Public Health Association. The Rotary Clubs, the State Bureau of Education, the State Medical Society, and the State Department of Health all pledged their cooperation. Three clinics for crippled children, arranged and paid for by local groups, have been held already and nine more will be conducted in various parts of the state. In Aroostook County alone 101 children were examined and 70 found to need operative care which will be given as rapidly as possible.

A request from the Scarborough School for a health study was honored, because it gave an opportunity for this Association to suggest standards for improvement in an outstanding private day school, the results of which might be of benefit to a large group of such schools. The report, which was prepared by the Medical and Health Education Divisions, has been pronounced very helpful by the Director of the School.

At the request of the Acting Governor of the Panama Canal Zone,

two members of our staff, with their expenses to be paid by the government, were appointed to assist during January and February, 1924, in establishing a health education program for school children of the Zone. The Zone Departments of Health and Education accepted the proposals for methods of teaching health through the various subjects of the curriculum and agreed to place scales in all the schools. They also agreed that:

1. Parents should be present at yearly physical examination of children.
2. A report of the children's condition should be sent to teachers and club workers.
3. A record should be kept of all corrections secured, and these should be compared with defects noted by physicians.
4. All children should be weighed as a part of the doctor's examination and the weight should be recorded.
5. A campaign of publicity should be launched over a period of months on matters relating to child health, viz., green vegetables, long hours of sleep, the use of powdered milk as a necessary substitute for unavailable fresh milk, and so forth.

As the organization of the Zone did not place the responsibility for carrying out such a program in the hands of any one person, the approval of each of the divisions was secured through the acceptance of recommendations by its representative.

Further plans were offered for consideration of the Bureau of Clubs and Playgrounds and recommendations were made for the Kindergartens and play centers, and for women directors of the activities of the older girls.

At a conference of 150 people, including all workers among Indians on the Rosebud and Pineridge Reservations and teachers from the Sioux Reservations, called by Mr. Peairs, Chief Supervisor of Education for the Indian Service, a staff member gave a course of lectures followed by working conferences on health education. This was described by a representative of the Indian Service as having given the teachers "a different viewpoint" and helped all present "beyond measure."

Concretely, this cooperation has already resulted in the preparation of a detailed program of health education for all Indian day and boarding schools in the United States, involving an effort to reach the parents of the children in the day schools as well as to influence the life of the children in the boarding schools. This program provides for the coordinated efforts of all workers in the schools, including directors of medicine, nursing and home economics, as well as matrons, housekeepers, farmers, superintendents, principals and teachers. Furthermore, Mr. Peairs has decided that teachers who are to serve in Indian schools

will be expected to attend normal schools where health education is taught by approved methods. The continued cooperation of this Association is requested in carrying out these plans which should benefit every Indian child in these schools in the United States.

GENERAL OBJECTIVE III. PROMOTION OF MORE EFFECTIVE SERVICE BY EXISTING NATIONAL GROUPS

The Association has cooperated with the American Gynecological Society and the American Association of Obstetricians and Gynecologists through a Joint Committee on Maternal Welfare, to which a small appropriation was made for the purpose of broadening interest throughout the country in the problems of proper care for the mother before and during confinement. (This cooperation, together with the midwifery demonstrations noted elsewhere, the seven state birth registration campaigns, and the added knowledge and experience given to physicians and nurses in the subject of prenatal and maternity problems through scholarship awards and also its assistance in study and organization of local work in so far as it has dealt with prenatal and maternal service, constitute the contribution of this Association to the effort to reduce this country's high maternal mortality rate.)

Physicians. Fourteen selected physicians engaged as health officers, school medical inspectors, pediatric teachers, and practicing pediatricians, with residences scattered from Racine, Wisconsin, to Bay Minette, Alabama, have enjoyed the opportunity of improving their knowledge of child health work through the scholarships granted by this Association. These grants ranged from \$300 to \$800 each; terms of study extended from three weeks to a year, and methods varied from formal resident post-graduate work to traveling observation in leading centers of this country and Canada. Already results are being reported such as initiation of child health programs by health officers, promotion of immunization campaigns, spread of interest in child health to practitioners in the surrounding country, as well as great stimulus to the individual scholarship students in practice of up-to-date preventive pediatrics.

The 20 nurse scholarships have served several important purposes in the development of the work of public health nursing. First, they have given the opportunity for advanced study to 20 nurses. Secondly, seventeen of the nurses have returned to the positions which they formerly occupied, which is a definite contribution to these pieces of work in every section of the country. Two have taken advanced positions in the teaching of nurses. One is still studying. Thirdly, facilities for the

teaching of public health to nurses have been discovered and stimulated, and important teaching centers for nurses have been stimulated to include more of the foundation of health teaching in their curricula. Fourthly, a closer and better connection than ever before has been built up between this Association, the National Organization for Public Health Nursing and the localities from which the nurses came and the schools in which they studied.

Last year \$10,000 was awarded in teachers' scholarships, to train individuals in leadership and in original experimentation, and also to stimulate the development of adequate training courses in health education in universities and elsewhere. Of the 24 teachers receiving awards, 14 attended university summer schools in 1923 and ten have been carrying out their work through the 1923-1924 school year.

Of the latter, five actually gave health education courses in 1924 summer sessions at the following centers: University of Michigan, University of Rochester, State Agricultural College, Corvallis, Oregon, Chautauqua Institution (two courses given full credit at New York University), and George Peabody College for Teachers. The demand for the services of these scholarship students is striking evidence of the need for training others. Also, this fall, five of them occupy strategic university positions as faculty members, health education directors or otherwise.

Of the holders of smaller scholarships for classroom teachers, one has an important position in the health education department of a large city school system and another is in charge of teacher training in a city with an interesting health education program. The majority have returned to elementary schools and will be followed with help and advice as they develop health programs in their local work.

The Metropolitan Life Insurance Company's appropriation of \$25,000 brought applications from 1,644 teachers in 52 of our largest cities, scattered from coast to coast. On June 2, 1924, 50 were granted scholarship awards of \$500 each; 36 took summer courses this year and 14 have chosen work during the 1924-1925 school year.

The outstanding result, thus far, of this unit of work, is the increased interest in health education in these 50 cities. Local committees, which coöperated in the selection of the teachers, included as a rule the superintendent of schools, a health department official, one representative of the teachers' organization, and others from civic groups. These committees served as centers of education for the community. In three cities they are promoting organized courses of health education for training teachers and a number of others may do likewise.

An interesting development has been the spontaneous organization

of these teachers as a group under the title "Scholars and Fellows of the American Child Health Association." The group plans to meet once a year and to exchange experiences in the interim.

In June Dr. Richard M. Smith of our Medical Committee conducted a demonstration of the points indicating normal physical health in the well-grown boy and girl, before club workers in the cooperative extension work in agriculture and home economics in the State of Rhode Island. This demonstration was under the auspices of the United States Department of Agriculture, and reached about 225 individuals who have charge of the work of over 2,500 boys and girls in Rhode Island.

Besides the permanent help to universities, through assistance in organizing courses on child health, staff members have reached over 1,000 students (many of them studying to be leaders in their fields) with direct instruction in child health problems and work.

The Health Education Division has given special help in two ways:

(1). Courses given at the solicitation of the institutions mentioned:

(a) *Iowa.* During June, 1924, a member of the staff gave a three weeks' lecture course in the Summer Session in the University of Iowa. The work consisted of two separate courses, one designed for teachers of physical education and the other for supervisors, superintendents and principals, and was of special importance at this time because it was aimed to equip teachers to carry out a new law requiring physical and health education to be included in all school programs of the state.

(b) *New York University.* The Health Education Division assisted in planning and choosing the personnel for a course in health education during the summer session. We were able to arrange with the Ethical Culture School to have its play school used as a practice and demonstration centre during this period, the guidance of the student teachers being carried by a staff member.

(2) Isolated lectures given separately or as part of Health Hygiene Courses.

Lectures in health education were given to 15 universities, normal schools and special schools in ten different states during the past year, a number of these being a part of the regular health course. Addresses were given and conferences held with numerous national groups, particularly home economics and physical education teachers.

Lectures were given by representatives of the Medical Division in four universities as part of regular courses in public health or pediatrics, as follows: University of California, Johns Hopkins, University of Louisville and Columbia University. Also at Columbia University the child hygiene section of the public health course, with 23 students attending, was organized and conducted by the Secretary of this Association. Two of the lectures were given by members of the staff.

The Association's representative in the Far West conducted a week's course at the summer Nurses' Institute of the University of

Washington, and a course of two weeks at the summer Child Health Institute of the University of Oregon.

The Division of Nursing loaned its secretary of School Nursing for courses at the University of Louisville, the University of Iowa, the University of New Hampshire and the School of Social and Health Work of the University of Pennsylvania.

A member of our Medical staff aided in the development of the pediatric department of the Louisville University Medical School, and also in the establishment of closer relations for the furtherance of child health work between the Louisville University and the local child health groups.

The member of the staff who was loaned to the pre-school committee of the Parent-Teacher Association of Georgia has so effectively brought together the Federated Women's Clubs and the Parent-Teacher Association, in cooperation with the State Council of Social Agencies, the State Board of Health and other organizations that these groups are now planning to raise a sum sufficient to carry such a worker to continue the coordination of volunteer child health work in relation to that of the public departments.

GENERAL OBJECTIVE IV. PUBLIC INFORMATION AND EDUCATION

In addition to the tremendous interest aroused over the country by the preparation for and the observance of May Day as Child Health Day and the follow-up of this interest, as described before, the Association has steadily carried forward its educational service through publications and educational and news articles.

The *Child Health Magazine* has been nearly doubled in size. With a greatly improved format and a larger circulation it has been much commended. A fuller participation in the magazine's editorial plans by the professional staff of the Association has been arranged. This, with the lively interest shown in it by authorities in the field of child health in every part of the world, gives ground for the belief that it can serve even more acceptably as a monthly clearing house for information available on the subject.

The circulation of our books and pamphlets by schools and health agencies has greatly increased. But most significant, as showing the nation-wide interest in the subject of child health, is the demand for these publications from purely commercial concerns for distribution among their customers. A bank in Iowa ordered 500 copies of one booklet. Another bank, in Indiana, ordered 1,000. A dry goods store in

Kentucky ordered 500, and distributed them in connection with a course of lectures by child specialists in cooperation with the Bureau of Child Hygiene of the State Board of Health. A dairy council in Pennsylvania ordered 10,000. We are now negotiating the distribution of certain of our titles in million lots through the retail dry goods stores of the country.

Schools and health agencies are our regular customers but when one State Board of Health orders 25,000 copies of a single booklet to be used at the time of its annual tuberculosis clinic examinations, following with orders for 25,000 of our pre-school cards and 25,000 height-weight cards and 1,500 larger pamphlets, there is indication of the sales possibilities in this field. Another significant order for 500 copies of a single booklet came from a church in Connecticut.

The purpose of the newspaper publicity has been educational rather than merely to advertise the Association and its work. Newspapers have editorially commented upon such service, referring to it as "legitimate publicity." Their cooperation has been invaluable. One instance was the release of the infant mortality statistics with critical analysis of conditions in the different states. It provoked wide-spread editorial discussion. In certain states the newspapers have used our material to agitate for the inclusion of their states in the Birth Registration Area, to urge clean and safe milk campaigns, to demand that additional funds be made available for state health departments. In the future such releases should be even more effective. Our plans contemplate closer cooperation with the Conference of State and Provincial Health Authorities so that we will include in our articles sent to the newspapers facts supplied by the health officers. Many of the state health bulletins release our press material with their own.

There has been a strong demand for our educational material from the foreign language press. Hundreds of articles have been sent out in German, Spanish and Italian on special subjects, particularly on birth registration and clean milk. Articles in other languages are being planned.

The report of the International Health Education Conference of the World Conference on Education (June, 1923) has been distributed to 275 educational and government officials in all countries in the Pan-American Union, 25 more going to the Inter-American High Commission, parts of this report being reprinted in Spanish in the *Bulletin of the Pan-American Union* for free distribution at the Fourth Pan-American Conference on Child Welfare which was held in Chili, October 12-19th.

Another educational project with newspaper aid and support is the

syndication, now under way, of a series of 96 articles on various phases of child health. These articles were written by eminent pediatricians. Doctor Holt edited them with a view to making their appeal popular rather than scientific. They will later appear in book form. Both the syndicated articles which are sold to newspapers, and the book which will appear with our other publications in the Association's catalogue, are part of the plan for increase of revenue by the sale of services.

In addition to strengthening the nursing equipment for advisory work as related to child health, the Nursing Division (the National Organization for Public Health Nursing) has published a series of articles in the *Public Health Nurse*, provoking wide discussion of the problems of nursing as related to the schools.

CHILD HEALTH DEMONSTRATIONS

The Child Health Demonstrations now under way in Ohio, North Dakota, Georgia and Tennessee—and one planned for a Far Western center—have been called ventures in coöperative relationships between certain cities and counties and a national committee, "in the interests of the mothers and children of these communities and of the nation."

Their purpose is to produce and develop practical programs of community and child health, which shall serve many other communities as well as the individual Demonstration centers. Achievement of an ideal program is not expected, but it is the hope that each demonstration community will show gain in development of resources and standards which will extend to other communities.

The direction of these Demonstrations has been entrusted to the American Child Health Association by the two committees jointly representing the Association and the Red Cross in one instance, and the Association and the Commonwealth Fund in the other—which are in administrative control of the respective Demonstration programs.

The progress of the child health demonstration financed by the American Red Cross and of the three others financed by the Commonwealth Fund, which are already under operation, has been very gratifying to the national committee which are directing the Demonstrations through affiliations with the American Child Health Association.

It can be broadly stated that community interest and co-operation are real and effective in each of these demonstrations, but the actual evidence of financial support for health work which has been developed since the Demonstrations were begun is much more conclusive proof. New appropriations for health work from other than national demonstration funds have reached the gratifying yearly total rate of \$57,962 in

these four demonstrations centers, of which \$4,000 has come from the State. The amount from local sources has varied from over \$25,000 in Mansfield and Richland County, where the work has been under way 2 years and 9 months to \$8,007 in Athens, where the demonstration has been in progress only 9 months.

Some details of accomplishments will be mentioned under each of the Demonstrations.

Mansfield and Richland County, Ohio (Begun January, 1922)

The most notable fact has been the combination of the city and county health personnel into a whole-time joint health department and the appointment of the Director of the Demonstration as Health Officer, thus centering responsibility for the maintenance of much that the Demonstration has started. The new joint Health Department is actively broadening its program of sanitary inspection and disease control.

In addition, it is noteworthy that the total appropriations of new funds from local sources for health work actually started since the demonstration began has reached the yearly rate of \$25,435.00, of which the Mansfield Public Health Nursing Association alone (through the Community Chest) has contributed \$7,801.90 in support of the nursing staff.

Under the Council of Social Agencies there has been developed a case work committee, with the co-operation of the Director of the Demonstration, which has done much to bring together the work of the different agencies and to establish better standards. The Council is also attempting to bring about an even closer correlation of such work in the districts of the demonstration area.

The medical and nursing work carried on under the auspices of the Demonstration has been increasingly accepted by the community as a part of the community program. During the past 12 months a total of 1,276 children have been seen at medical conferences, of which 666 were babies, and 610 pre-school children. Excluding Shelby, 1,989 school children were given complete health examinations, attended by an average of 17 per cent of the parents. Nursing visits were made to 330 prenatal cases, 2,000 babies, 940 pre-school children, and 1,797 school children. Dental examinations of 2,727 children were made. The health education and nutrition programs have been effective in reducing the number of underweight children and infusing the entire school curriculum with the modern health idea.

An effective feature of the school health work has been the award of blue ribbons to the children whose correctable defects have been cor-

rected. This method has proven a powerful stimulus to the improvement of the physical condition of both pre-school and school children. Because of the wise and careful guidance of the use of this method it has helped to increase materially the interest in the whole health program.

One of the most significant developments during the year was a symposium emphasizing the preventive phases of pediatrics for the local practicing physicians, arranged at their request by the Director of the Demonstration and the Medical Division of the American Child Health Association. This included lectures, clinical demonstrations and discussions by outside specialists brought in for the purpose and was pronounced a great success by the physicians.

The nursing work has been used by the Western Reserve School of Nursing for field observation for three groups of student nurses, and the Normal Training Course in Mansfield is being recognized by representatives of the State Department of Education as a valuable contribution to standards for such work throughout the state.

Fargo, North Dakota, Child Health Demonstration
(Begun January, 1923)

Following the establishment of a whole-time Health Department in July, 1923, the Health Officer, co-operating with the Director of the Demonstration, has made a sanitary survey of the schools; a survey of privies with increased activity for improving sewer connections; 500 vaccinations of children and adults, with an estimated addition of 1,300 made by local physicians and a more thorough enforcement of laws governing the purity of the milk supply.

The total appropriation of new funds, from local sources, for health work actually started by the Demonstration or since it began has reached the yearly rate of \$14,860.00. This includes the rental value and upkeep of the school building assigned as headquarters for the Demonstration.

At the request of the physicians of Fargo, the Director of the Demonstration, with the co-operation of the Medical Division of the American Child Health Association, conducted a pediatric symposium, in which the preventive phases of pediatrics were emphasized. A number of eminent physicians in special lines were brought in to give lectures, clinical demonstrations, and to conduct discussions which were considered very helpful by the Fargo physicians.

At the North Dakota Agricultural College a course in health education is being carried on, in co-operation with the science faculty, in which 30 Fargo teachers are enrolled. The stimulating effect of the

Health Education program of the Demonstration is remarked upon by all observers of the schools. The number of children of normal weight or above, according to the Baldwin-Wood Tables, increased from 1,128 to 1,487 during the school year 1923-24. An incidental effect of this program has been the increased serving of milk, two and one-half times as much being served as in the previous year.

There has been a total of 614 children other than school children under medical supervision during the year. In addition 1,253 mothers and children (of which 102 were prenatal cases and 1,151 children under six) have been visited by the nurses. Varying with the schools, 20 to 65 per cent of the parents of the 3,027 school children examined showed their interest by their presence at the examinations. In response to the efforts of the Demonstration, 1,800 children made voluntary visits to dentists for oral examinations.

The Demonstration has continued the work which it undertook in the health supervision of institutional mothers and children, 115 service visits to institutions having been made in the past year. The standards which it has developed have influenced the policy of the newly formed Children's Bureau of the State Board of Administration.

Other activities have been the opening of a Fresh Air School in October, 1923, in which the children have shown an average gain in weight of 5.6 pounds during the school year. The second summer term of the Fargo Play Centers was supported by the Rotary Club and there was an average attendance of 225 children.

Athens, Georgia, Child Health Demonstration (Begun January, 1924)

The co-operation between the Health Department and other work in the Demonstration has been so close that it has been carried on practically as a unit. The genuine community interest in the Demonstration has been practically illustrated by the financial support which has been forthcoming during the eight months since the Demonstration work began. The total yearly rate of new local funds supplied has been \$8,007, including estimated rental of headquarters, salaries of a Supervisor of Health Education, an additional nurse, and a sanitary inspector, including also an appropriation of \$1,200.00 for playground equipment, held by a local committee for lack of direction of such work, which became available in June by the appointment of a Supervisor of Physical Education, paid by Demonstration funds.

The Demonstration has recently undertaken the support of an oral hygienist. Following a subsidy from Demonstration funds for a full-time bacteriologist, this worker is now paid by the City of Athens. The

Commonwealth Fund has furnished the salary of a Director of Health Education for the Normal School.

New activities resulting from these additional workers have been bacteriological studies of the water and milk supplies; four health centers ready for permanent operation with itinerant clinics to be held monthly in rural schools; the supervision of two playgrounds during the summer months; a preliminary survey of mouth conditions of children in the colored playgrounds; an intensive effort during the summer for health examinations and immunization of children about to enter school in September; a summer course in public health at the University of Georgia and the establishment of an out-patient department at the Athens General Hospital.

*Rutherford County, Tennessee, Demonstration
(Begun January, 1924)*

The health work of the county is headed by the Director of the Demonstration who is also Health Officer of Murfreesboro and Rutherford County, creating for the first time a whole-time health department. Achievements of this department, so far, have been complete small-pox vaccination of Murfreesboro school children, improvement in sanitary conditions of abattoirs and dairies; the oiling of mosquito breeding places as the beginning of a campaign against malaria; improvement in sanitation of county schools; and the preparation of score cards which will be used in grading the school on a sanitary basis. Provision is to be made soon from local funds for quarters for a venereal disease clinic and also for an eye and ear clinic which is being developed by the local physicians.

The total yearly rate of new state and local funds supplied for health work has been \$9,660 of which approximately \$4,000 comes from Sheppard-Towner funds through the State Department of Health.

The health education program, begun in the schools in the spring of 1924, is developing with the active co-operation not only of the Superintendent of Schools but of the individual principals and teachers. Provision for the continuity of the program has been made by direct educational work with the teachers. The Demonstration staff conducted a summer course in Health Education at the Middle Tennessee State Normal School, with 87 students enrolled; and a similar course is being given in the fall quarter of the Normal School, with 100 per cent attendance of Rutherford County teachers arranged for.

Well-children's conferences have been held in Murfreesboro since March; and rural conferences have been held in the county since June.

The major attention of the Medical and Nursing Divisions of the Demonstration has been given to school children, 1,502 children being given partial health examinations in the spring, and the defects followed up with great care by the nurses during the summer.

The Far Western Demonstration

A child health demonstration program along similar lines will be organized in a community of the far west early in 1925.

PROGRAM FOR 1925

With the tangible results of our past two years' work to build upon, the increased good will from effective cooperative action with local, state and national groups and an increasingly clear view of the problems and the best methods of work, the Association faces an even more hopeful opportunity for telling service in 1925 than during the past year. The proposed program of work for 1925, and an estimate of expenses necessary to carry out this program, are before the Board of Directors for consideration and action. Attention is called here to certain outstanding features of these proposals for the coming year.

One of the central features is concentrated assistance to states and communities. As has been said by the Committee on Future Plans and Support of the American Child Health Association:

"As we review the activities of the Association, the demands upon it and plans for the future, we can begin to see the outlines of a definite pattern for the coming work of the Association. Instead of building up an ever increasing number of individual contacts, it will lend its knowledge and its services in larger measure to governmental agencies, organized groups and training centers, in the belief that in this way it will not only multiply its own usefulness but, at the same time, will contribute most to the sound principle of developing local and state resources to the highest degree possible."

A notable tendency in the work suggested for 1925 is the swing westward of such services as those of our milk survey staff, birth registration workers, and others. A legitimate complaint against many national organizations has been that their aid has been confined too largely to the eastern half of the United States. This Association has followed the policy of meeting requests for aid from any section of the country to the extent of its ability, but we believe that those in the western part of the country should, as far as possible, receive greater recognition, because of failure of the West in the past to receive its due share of such assistance from national organizations, including this Association.

We set for ourselves this year the task of securing a true picture of conditions relating to child health in this country. In the program

advanced for 1925 it is proposed to supplement these valuable data on *conditions affecting child health* by more information as to the *actual health status of individual children*.

Studies of the *health of children* are proposed in a number of the 86 cities already surveyed as to the *machinery for child health work*. These studies, it is hoped, will give further impetus to organized local effort and at the same time afford valuable data for the guidance of child health workers in concentrating their efforts where they are most needed. As an appropriate corollary to such studies, a survey of the health of children in institutions, as urgently requested by the Child Welfare League of America and Dr. John Lapp of the National Catholic Welfare Council, is included among the activities recommended for the coming year. Examination of children of certain age groups is to be carried forward as rapidly as possible in the Demonstrations under the administrative care of this Association.

While the study of the condition of the health of children is progressing, the Association should be prepared to concentrate also upon promoting the extension of the plan by which communities may study and rate their own activities relating to child health and public health generally, according to the rating system developed by this Association in cooperation with the Committee on Municipal Health Department Practice of the American Public Health Association.

We gave as one of our major objectives this year, assistance to the existing national groups in increasing the effectiveness of their service to the health of children. We believe that achievements of the Association along this line have been valuable and its efforts to broaden the basis of responsibility for the health of the children of the nation should be increased rather than diminished. Our cooperation should be continued with every interested group, private as well as public, lay as well as professional. The training of professional workers should continue a major objective, and the Health Education Division is planning to give concentrated attention to the training of teachers in health education, including the preparation of courses of health education for normal schools. It is a matter of regret that, within the limitations of our next year's budget estimate, provision for scholarships for physicians, teachers, and nurses has not been possible except for one fund of \$1,000 for teachers' scholarships.

In co-operation with other national health groups, it is hoped that next year the Association may begin the preparation of a clear and comprehensive statement of the best modern health methods and practices in every field relating to the health of the child. The plan is to study those communities where especially good results have been secured in

important phases of child health work. The findings from such studies will then be presented in such form as to be most serviceable as a guide to communities everywhere. This would seem to be a logical next step, following the preparation of the system of scoring communities in their child health work which has already been developed.

One of the most important objectives of the Association during the coming year should be to aid in tying more closely together the national groups in the health field, looking toward an eventual amalgamation of public health agencies. To this end, this Association ought to throw its whole weight behind the effort to make a real and vital force of the proposed Joint Field Service Bureau under the National Health Council (which grew out of the joint efforts of this Association and the American Public Health Association for rating communities).

As during the past two years, one of the responsibilities of the Association that is of greatest importance, is the supervision and administration of the demonstrations which have been placed under its charge by the American Red Cross and the Commonwealth Fund. The community changes of importance that have come about within these demonstrations indicate that the Association is giving real help to the stimulation of child health throughout the nation in continuing its supervision of the more intensive program of work in these five selected communities in different parts of the country.

APPRECIATION AND CONCLUSION

Appreciation cannot be adequately expressed for the leadership of Mr. Hoover and the directors in the affairs of the Association during the past year. The time and attention given by Mr. Hoover personally and the weight given to the Association by his name cannot be estimated. The individual services of many members of the Board have been a very great source of strength.

The quality of service given the Association by heads of the various Divisions and other members of the staff has been of a very high order, and, together with the spirit of team work, has been largely responsible for the achievements which we are able to record.

I want to pay a very warm and hearty tribute to the splendid co-operation that this Association has had from the others that have been affiliated with it in the National Health Council and from the other national, professional and civic groups and from the governmental bureaus which have cooperated with us. The spirit of cooperation has been increasingly expressed in mutual planning and service.

At the end of the second year of life of the American Child Health

Association, we can review a record of achievements which has surpassed our greatest expectations. We can now see more clearly what the future holds. In the course of the next two years, we should be able to complete some of the major services such as our milk and birth registration surveys and our assistance in laying out standards for the various phases of health work usually falling under the jurisdiction of health and school departments. We should also confidently expect, at the end of that time, to have done our share in so weaving together plans and activities of the various national agencies as to have practically eliminated any duplication of effort, if not to have actually accomplished an amalgamation of several important national health associations.

TRAINING LEADERS FOR CHILD HEALTH WORK

*Presiding, MAZYCK P. RAVENEL, M.D., University of
Missouri, Columbia, Missouri*

Community Child Health Program—Essentials of Preparation for:

a. Physicians

*CLIFFORD G. GRULEE, M.D., Associate Professor
of Pediatrics, Rush Medical School, Chicago, Illinois*

b. Health Educators

*C. E. TURNER, Professor of Biology and Public
Health, Massachusetts Institute of Technology,
Cambridge, Massachusetts*

c. Public Health Nurses

*SOPHIE C. NELSON, R.N., Director Visiting Nurse
Association, St. Louis Missouri*

d. Community Organizers

*E. L. MORGAN, Professor of Rural Sociology,
University of Missouri, Columbia, Missouri*

Discussion:

RICHARD M. SMITH, M.D., Boston

THOMAS D. WOOD, M.D., New York City

TRAINING LEADERS FOR CHILD HEALTH WORK

Presiding: MAZYCK P. RAVENEL, M.D., University of Missouri, Columbia,
Missouri

The increasing demand for public health work along all lines has brought the realization that there is dearth of trained workers, and for several years past, many conferences have been held to devise ways and means of supplying this deficiency. It is fitting, therefore, that a session of this meeting be given up to the problem of training leaders for child health work.

The reasons which justify child health work have been repeated so often that they are familiar to all of those interested in this line of endeavor. For those in the audience who have not before this time paid special attention to the subject, they may be summarized under four heads:

First: The children of today are the citizens of tomorrow, upon whom the duties and responsibilities of this country must rest in the near future.

Second: Child health work has been, with the possible exception of the suppression of some of the insect-borne diseases, the most strikingly successful health work yet done.

Third: From the biological as well as the practical standpoint, there is no line of endeavor in public health which promises as much for the prolongation of life as child health, including pre-natal as well as post-natal work.

Fourth: The remarkable decrease in infant and child mortality is responsible, more than any other single factor, for the great increase in the expectation of life which has taken place during the past two generations, and particularly during the past ten years.

Not only then can we appeal for support on the ground of notable accomplishment, but we have a further advantage in the fact that child welfare appeals to the best side of human nature.

ESSENTIALS OF PREPARATION FOR PHYSICIANS IN A COMMUNITY CHILD HEALTH PROGRAM

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It is not so many years since it was deemed perfectly plausible for a man to step without further preparation from a general practice into the specialty of pediatrics. In fact, most of the leading pediatricians of some years ago had their training primarily in internal medicine and went from this to pediatrics. It is a far cry from that period to the present, when we are not only training men as pediatricians, but are also training specialists in various phases of pediatric work.

In choosing a physician for the purpose of directing a community child health program, it is not only necessary that one take into consideration the medical training which this individual has had, but also that his various other attributes for the purpose of attaining the end in view be considered.

In the first place, a man must have a large knowledge of medicine in general, since his work will touch upon almost every phase of medicine. In the second place, he should have a thorough knowledge of public health work and its problems, and since so much of public health work now consists of work among children he must have essentially the training of a health officer. Situations which he must meet may be divided into the following phases: prenatal work, infant welfare work, pre-school age work, nutrition work among older children, contagious diseases, general sanitation and the mental and behavioristic problems peculiar to childhood. His knowledge of public health work cannot be too strongly emphasized.

1. The period of highest mortality and the period in which mortality has been least reduced, is that of the newborn. The physician must, therefore, have an adequate knowledge of prenatal and obstetrical conditions which have a bearing upon the mortality at this age and he must have some general knowledge as to the accepted means that are being employed to combat these conditions.

2. The physician is most likely to be well trained in infant welfare work. This branch of public health has made phenomenal advances during the past 15 years all over the world and especially in the United States. The problems that this age period presents are being met successfully perhaps more successfully than the problems of any other age period. It is not necessary to emphasize the importance of this subject to anyone who would lead a community in child health work.

3. The pre-school age offers some difficulty, principally because of the fact that mothers are not inclined to bring children of this age to clinics. This phase of infant welfare work, therefore, should be one with which the physician is familiar and the importance of which he must understand.

4. Nutritional work among older children in many ways has not received the attention which it deserves. Few people realize how many children wish to go into gainful occupations at the early ages of 14 and 15, nor do they realize how many of these are physically handicapped. It is necessary that the physician who undertakes a child health program be able to emphasize this in the schools and be able to outline a general program for child health during the school age.

5. It is not necessary to dwell here on the importance of a study of contagious diseases for the purpose of a child health program. The advances in the past few years along this line have been truly phenomenal and it seems fair to assume that it will be but a comparatively short time before we will be able to control the most serious of these. The man who has to do with a child health program must not only know that these opportunities for control exist, but he must be able to convey that knowledge to the community.

6. We shall not dwell upon the necessity for a knowledge in general sanitation, because such is self-evident. This phase of the situation, however, rarely comes directly under the supervision of one who has to do with community child health. As a rule, sanitary problems are taken care of by health departments.

7. Last, but by no means least, is the necessity for having a conception of the mentality of childhood, of deviations from this mentality and of behaviouristic disorders.

We see, therefore, that the training of a physician who would competently serve as director of a child health program in any community must be of the highest order medically. But even if such a physician have all these attainments in the highest degree, he may still fail.

Few public health workers outside of the medical profession realize that public health is private health, that the ultimate attainments of public health rest, not with the director of a child health program, but with the physicians of the community in which that child health program is being carried out. Nothing has gone further to prove the necessity for individualization in public health work than the success which has been attained by the infant welfare stations in the larger cities of this country. No other effort has so successfully demonstrated the necessity for individual medical and nursing care in order to bring results.

The man who goes into a community with the idea of formulating

a child health program must always keep in mind that the ultimate success of his project will depend upon the physicians in that community. Not only must the physicians of that community be willing to aid in such a program, but they must be able to do so. The director must, therefore, have a wide sympathy for the medical profession. He must have an ability for organization and an ability to stimulate the profession to greater efforts on behalf of the children. He must be able to estimate the ability of the medical profession of that community to aid him in that program and he must be able to assist them to add to the knowledge they already possess. To accomplish these things means an unusual combination of personal qualities. Without giving up his purpose, he must command a sympathetic action on the part of the profession. He must educate the community to realize that while there are general rules in medicine, as in everything else, the application of these rules must be carried out, not by one uneducated in medicine, but under the supervision of one who has a definite knowledge of the conditions to be encountered. In other words, his efforts should always be towards raising the credit of the medical profession in the eyes of the laity.

Progress in medicine, as in all science and in all human effort, is slow and he who would promote a child health program must be satisfied with small things. It is not possible to educate a community in a few months. You may arouse its enthusiasm but to have it convinced, is another matter. It has taken a hundred years for the world to realize that small-pox can be prevented by vaccination. We are just beginning, after ten years of intensive effort, to make communities think of diphtheria as a preventable disease. It has been one of the strong points in the American Child Health Association that it has not been carried away by the program of the day, that it is held fast to facts and investigated theories. It has kept away from the hysterias of the child health program and it has for this reason built up a solid foundation.

One who will successfully carry out a child health program in any community must not measure that success in months, but in years. The reduction of the infant death rate during one summer, or the prevention of diphtheria in one group of children is not the measure of his ultimate success. The ultimate success of that program consists of convincing the community that the measures used for reducing that infant mortality and the measures used for preventing diphtheria, are those which they would be glad to apply as general measures for their continued betterment. To meet such results, I must repeat again that the medical profession of the community must be the first convinced. Not only must they be convinced, but they must be made the crusaders along the lines of child health.

ESSENTIALS OF PREPARATION FOR HEALTH EDUCATORS IN A COMMUNITY CHILD HEALTH PROGRAM

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We may accept the proposition that every grade-teacher is a health educator in the child health program. Whether she wants to or not, and whether she knows it or not she is teaching health or lack of health, and it is only through her that the health education program can become effective. For this reason it is of vital importance that the teacher training institution should fit her as well as possible for this responsibility.

The Health Education Conference held at the Massachusetts Institute of Technology in June, 1924, pointed out that the kind of health instruction provided for the student teacher must vary with the five different classes of teacher training institutions. The most important needs in the more advanced institutions were said to include:

(a) Adequate development of the students' personal health involving healthful environment, medical examination with the correction of defects and a healthful school regimen arranged by the administrative head of the institution and supported by every department of the school. This is certainly a sound principle in the training of any type of health specialist.

(b) A first year course in Hygiene directed primarily to improving the health of the student.

(c) Supplementary subject matter courses according to the facilities of the institution.

(d) Subsequent special training and practice in methods of teaching health.

We recognize the basic need for the fundamental sciences taught with the approach which makes them most useful in the life of the teacher. For teachers in service we need to expand the opportunities to secure special courses in both subject matter and method. In the future we should require our teachers to enter upon their duties with a sound if elementary knowledge of physical, mental and community health and a knowledge of the fundamental methods of attaining these various phases of health.

But this discussion upon training leaders for child health work refers more particularly, I suppose, to the training of the people who are organizing and directing the health education program for children. While it is true that health training is fundamentally the job of the indi-

vidual teacher, that all teachers must participate if the program is to be successful, and that the development of a corps of specially trained individuals to undertake this teaching in place of the great body of teachers would be unsound, it is also true that functioning, continued, organized and uniform programs can be maintained only where some properly qualified person provides the necessary amount of leadership and supervision. Such leadership is being provided at many places in this country by people who have approached this new task along quite different paths. Leaders of exceptional quality who have developed the health training program have come from the groups of school administrators, physicians, teachers, directors of physical education, nutrition workers and nurses. There is much to be said in favor of "home grown" leadership, and it would be unwise as well as impossible to perfect and patent in any great educational center a new and standardized product for which the producer should attempt to secure a monopoly upon the business of directing health education activities.

There are two roads by which training in health education may be reached. If a person knows upon graduation from high school that he or she wishes to enter this particular field, such a person may enter the University and arrange a course for the bachelor's degree which will supply excellent training in health and education. The other procedure is to take the fundamental training in some one of the above mentioned fields from which health educators have been recruited and to supplement training and experience in that field by what is essentially graduate work or specialization.

Each of these procedures has some advantages and some disadvantages. The first method is most purposefully pointed toward the ultimate objective, but on the other hand some professional experience is often required before such a graduate will be entrusted with supervisory activities, so that there is much to be said in behalf of the professional background and experience provided by the second method. The desired training and qualifications are the same, however, in either case.

May I set forth here the principles of training in my own department, not through dogmatism or overconfidence, but rather with the feeling that a frank statement of our experience will be more purposeful than mere theory and with the hope that we may have the benefit of your constructive criticism?

We assume that three different fields of knowledge are necessary for the specialist in health education. The first is hygiene and public health. A knowledge of the facts relating to health includes the necessary foundation in physics, chemistry and biology with the superstructure of anatomy, physiology, nutrition, bacteriology, sanitary science,

the nature and control of communicable diseases, and personal and community hygiene. That is the subject matter the elements of which are to be taught. We want to be sure first that we are teaching the right things and then find out how to teach them best. We do not want to teach falsehood, even though the technique be perfect; and the specialist in health education needs a broad and sound scientific background.

The second field of knowledge is teaching method. If the student lacks a sound training in this field, courses in principles of education, educational psychology, teaching method and educational sociology at the School of Education are prescribed. In addition, every student must do not only observation work, but also must complete 90 hours in practice health teaching under supervision. This includes work with all grades of the elementary school system. It is practice, not in teaching mere cold facts, but in organizing and developing a broad health education program with each grade. If this person becomes a Director, she may work with teachers instead of children, but she needs the teacher's viewpoint and the knowledge of the possibilities and the difficulties of each age group which come from actual experience. This is learning by the experimental method.

The third field is a knowledge of the other health activities of the school and the community. The physical activity program is one of these. Sometimes the health educator who has been trained also in physical education has supervision of these activities. In other cases, the work is done by a physical education specialist, but even here the courses in the various phases of the activity program taken at the School of Education are of definite value. The health educator also needs to know the organization of school health work and the activities of the school physician, nurse, nutrition expert, or other specialists. There is advantage also in gaining sufficient knowledge of public health administration to understand the activities of the health department and the extra-school health agencies of the community. Practice work in a nutrition clinic for children and an opportunity for studying hospital cases of the communicable diseases of children are examples of study which yield facts and, at the same time, a knowledge of methods of applying them.

Upon this basis we arrange each student's program. There is no set course for everyone. The one principle of universal application is that each student in health education like graduate students in other departments, shall have an individual program planned by an advisor and based upon the student's previous experience and future aims.

There is much to be said for this close contact between the student and advisor. It has led us to make available to our students the facili-

ties of the other institutions of higher learning in Boston. This making use of all of the facilities of an educational center you may call the European system of education. Then again, in order to succeed, the health educator must have the right spirit and attitude toward her work. She must want to serve children and teachers. No one will succeed whose central ambition is to demonstrate her superiority or to make money. The close contact developed between the advisor and the student makes it possible to present the human viewpoint and the opportunity for service, and to provide a sympathetic understanding of the other people with whom the health educator must work. It often makes it possible later to place the graduate in the position for which he or she is best adapted.

We have had in our classes students from every one of the professional fields mentioned above as supplying health educators and we are still of the opinion that it is wise to leave the door open to all these groups. The subject matter which the health educator should possess is generally agreed upon. This paper presents a conviction as to the value of three principles of procedure, which we regard as essential: (1) practice work under supervision, (2) personal consideration by advisors for each student in mapping out the proper program of study, and (3) personality development insofar as this is possible or necessary by demonstrating the opportunities for service and providing an understanding of the other people who participate in the health education program.

ESSENTIALS OF PREPARATION FOR PUBLIC HEALTH NURSES IN RELATION TO THE CHILD HEALTH PROGRAM

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To arrive at a basis for discussion of the essential preparation for a public health nurse in relation to the child health program, it is important to consider the problems involved and the functions of the nurse in relation to these problems. Then we may find the essentials necessary to a successful performance of those functions.

There is no need to present to this audience the problems in child health, of which much has been written and more said until we know rather specifically what is the situation with which we are trying to cope. Perhaps not quite so specifically, but more generally, we also know what our line of action in relation to the solving of those problems should be; and we know too well for me to have to reiterate, the functions of a public health nurse in relation to a child health program. I do not need to "sell" you the nurse's importance or the value of her contribution to better child health. What is required of the nurse (or her function) must be the first part of an equation. The second part of the equation, namely, the essentials for accomplishing that function (which means preparation in the broadest sense of the word) must equal the first part.

There are two ways of arriving at the same conclusion about preparation. The first is to enumerate in detail the program, then consider the proportion of that program assigned to public health nursing—or at least the proportion the public health nurse should assume—and on this basis arrive at the essentials in preparation necessary for the maintenance of her part of the program. This would take a great deal of time to discuss, and we can arrive at the same conclusions by taking as our thesis a knowledge of the program and the functions of the public health nurse, and considering some of her successes and failures. From these we may draw certain conclusions as to the essential preparation necessary if she is to hold up her part of the program.

Broadly speaking, the contribution of the public health nurse in relation to her objective—the promotion of health and the prevention and cure of disease—is the teaching of the principles of health and hygiene. These loom large on the present horizon and represent a considerable change in the point of attack of some years ago which was, of course, first the cure and later the prevention of disease.

To be able to fulfill these most important functions, there are five essentials to be considered: personality, scientific knowledge, teaching ability, social understanding and organization of work.

Miss Josephine Goldmark, in her report of a survey of "Nursing and Nursing Education in the United States," comes to the conclusion that the greatest successes in public health nursing have been in the branch of nursing technique and in the application of our scientific knowledge in relation to disease. The failures have been largely due to the following: (1) Lack of fitness of character of some nurses for public health work; (2) Poor organization and (3) Lack of knowledge of the social aspect of disease, social problems and social case work. These failures are very natural inasmuch as many public health nurses of today have had no fundamental preparation in the very things in which their failures are most outstanding.

We can form a fair judgment of the essentials necessary to the proficient performance of any function, through a study of our failures and successes. So in this instance our failures and successes are a fair index of what has been our preparation in the past and what must needs be our preparation in the future.

I previously said that there were five major points which must be considered as requisites to "selling health." The first is personality. Inasmuch as our success depends so largely on the human relationship which we establish, and public health is really a personal conduct of life, it is essential that those people who are most concerned in putting over any public health measure have certain personal qualifications, some of which are inherent and others acquired. We are all born with certain characteristics, some we acquire and others we have thrust upon us. Public health nurses must have a keen intelligence and understanding, healthy physique, pleasing personality, enthusiasm, human understanding and sympathy, and by sympathy I like to think of the French definition, "A feeling with, not for." In other words, they must be seeing, thinking and feeling individuals. Plus that, they must be growing individuals—growing with the evolution of the need. Upon the ability to make satisfactory personal contacts rests much of our success in getting others to buy the goods we have to sell, because, as Professor Kilpatrick says, "We have not sold until the other fellow has bought."

In order to build a sound scientific structure, we must have as primary essential a person of intelligence who has acquired a good preliminary education, because she must be capable of assimilating the scientific facts which are the basis of her contribution. This means that plus the training given in relation to disease and its cure, she must also be given information regarding the normal physical and mental develop-

ment of children and early in her education added emphasis must be placed on the prevention of disease.

We must consider "teaching ability" one of our most necessary requisites and the knowledge of how to teach one of the first essentials in our preparation for public health nursing. Our successes are in direct ratio to our ability to teach and that ability is greatly dependent upon our knowledge of how to teach.

One of our outstanding failures has been a lack of social understanding. This has been largely due to faulty preparation. However well educated we may be in the care of the sick we have not always understood the social problems underlying physical disability and disease, a knowledge of which is absolutely necessary if we are to teach effectively, and if we are to utilize the assistance of others. In other words, we must recognize that the cooperation of other people is essential to the solution of the whole problem. Our failure in this respect would seem to demand that we have some knowledge of sociology and of good sound social case work. The nurse must use case work methods if she is to bring about a finer adjustment between individuals and their social environment.

And although we may possess the nurse with the requisite personality, the professional preparation and the understanding, we still may flounder on the rocks of failure through lack of organization of our work. The demands growing out of our many problems of child health are so much greater than the supply with which we are equipped to meet them that the best possible organization of our program is essential. Organization methods are something that we must acquire and in which we must be trained.

And so to summarize: Our preparation must be considered in relation to the essentials as outlined. We must have a well-educated person endowed with proper personal qualifications, who has acquired sound clinical training, knowledge of preventive methods, appreciation and knowledge of teaching and sound social understanding.

To solve the problems of child health we must come to the realization that no one single group of workers can contribute its maximum except as it works in close cooperation with all other groups. Interdependence of the many groups dealing with different phases of the work must be thoroughly understood and accepted if we are to attain the common objective—universal child health.

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ESSENTIALS OF PREPARATION FOR COMMUNITY ORGANIZERS

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In presenting this subject I have chosen deliberately to get rather far away from the thing I might be expected to discuss, namely curricula and methods of training to which task my time is largely given in the University of Missouri. I am going to talk of some of the general types of things which I believe the health worker who is going to do organization work ought to know. I am not at present concerned as to how or where she will get to know them, only with the fact that they represent the limiting factors in the success of a child health community project.

It is assumed that the community health organizer has completed the necessary studies in the field of child health and is thoroughly familiar with the technic of the health aspects of the work to be done.

I have come to think that the outstanding necessary first condition in all these new movements is a recognition of the community. Some people seem to have only just discovered the community. The community organizer needs to know what real community organization consists of. It has been disappointing to find the term used for this, that, and the other, with so little real meaning. People will say a community is organized, just because some particular job has been put over. The person who is going to attempt to "sell" something to a community in a constructive way needs to see community organization from the standpoint of adjustment of social forces, not from the standpoint of the putting over of a given program. It is in regard to this definition of community organization that I want to consider the question.

Community organization involves the bringing together of people, which always means adjustment and only in exceptional cases means agreement. Community organization in reality consists in such a bringing together of the people that the community may develop its own affairs in somewhat its own way, working out a program of activities through adjustment.

Before we can go far we need to be sure that our community organizer knows society. I would just as soon invite a physician who has never had a course in physiology into my home to treat my child as I would to ask a social worker of any sort to get anywhere in community organization who knew nothing about the nature and behavior of society. I want the social worker to know sociology which is the science of society—where she may get her sociology, whether in a curriculum,

or by reading, or by any other means, I do not care—I simply say she must have it.

We need to see society, for what it is, study its structure and behavior, see the way in which it acts, the way in which it determines whether we get a thing done or not. The social worker needs to know that society is a delicate fabric which may be vitiated by wrong usage, but which if dealt with constructively may be our developing medium. We must realize society as something always on the move, but whose progress is slow. If you say to a social worker "wait five years for your result" it seems too long—people want to get a job done in five days, five weeks or five months. We have to look at society as an organism, growing, moving, progressing, but very slowly. Once this is realized we are more inclined to plan constructive long term programs of work and avoid the quick results methods which are expensive and usually end in failure.

I would want the child health worker to understand that not all activity is progress. The hard-headed business man is inclined to say of us, that we have the idea that when we are creating a stir we are making progress. The business man knows that is not true. Let us apply to our work the modern measuring stick of progress.

We have to remember what an amount of accumulated inertia there is in American society. We say sometimes that we are doing something new, that here is a new phase: but we need to remember that we are not the first people that have tried to do things of a health nature for the community. Ignorance of this is another of the accusations that is made against us. Generation after generation of panacea carriers have visited communities, and people are inclined often to insulate themselves against these periodic shocks. The new health worker starts out ignoring this, and then, of course, feels discouraged and begins to feel that he or she has the worst community in the world to deal with, when the fact may be that the community is merely assuming an attitude of self-defense born of similar previous experiences which have promised much and delivered little excepting institutional exploitations. This feeling of mine about knowing society is the result of extended observation. During the past four years I have studied the question of why people in various forms of social work have lost their jobs. I have found that out of some six hundred who have lost or left their jobs of necessity, ninety per cent were satisfactory as far as subject matter and technic were concerned, but failed because they did not know folks. They were not able to make contacts, not able to get along with people. That study rather convinced me that a large portion of the preparation for social work needs to be the learning to know folks, plain old-fashioned folks, in

both their individual and their group relations, because it is on the basis of the primary or face to face group that most social work must be done.

We must see society from the standpoint of knowing how to study it. I have no sympathy whatever with the muckraking form of social surveys, but I have sympathy and belief in the type of study that enables the community health organizer to know the major conditions and characteristics which determine the normal attitudes and reactions of the community to things of a public service nature. The basis of the social control of the community that is to be dealt with must be ascertained in terms of the sway of the various social forces and factors. Such a study the social worker must make for himself. This does not need to be accompanied by newspaper publicity. It should be, rather, of the quiet pathfinder sort of study which discovers the mainsprings of individual and group behavior.

What kind of a community is it then from the standpoint of the social forces. Is it a custom community or a conventionality community? Do the people of the community prefer to do things in the way they have always been done, or will they accept a new way if it is clearly pointed out as a sane procedure. It makes a vast deal of difference which kind of a community it is. These two types exist in every state with all shades of variation and can be diagnosed with a fair degree of accuracy.

Is the community a goodwill community, dominated by goodwill, or is it controlled by resentment, that is, resentment among business and professional people, resentment between the north and the south sides, resentment between industrial and racial groups as well as between groups of different economic and social status. These two types exist, clear-cut, and you have to distinguish between them. Some towns would rather quarrel than get along peaceably. In others you find goodwill the dominant social force. The mechanics of procedure differ greatly between these two extremes. In some localities nothing can be done of a public service nature until goodwill has been at least partly established.

Is public opinion in the community constant, solid and substantial or is it of the vacillating sort that is for you today and against you tomorrow. Will the people give you time to work out a constructive piece of work or will they demand immediate results.

What sort of a community is it from the standpoint of sense of justice. The community where sense of justice is low is one in which you are pretty sure to have a hard job before you. If the sense of justice is high, you will have an easier path to follow, for an appeal to a sense of fair play for the health of the oncoming generation will meet a responsive attitude.

What are the social cleavages in the community. What are the groups or "gangs" whose attitude toward other groups is antipathetic and jarring. These differences may be based on race, religion, politics, education, occupation or on economic and social status. These things the community organizer must know. He must pick the community to pieces. These are the things which are determinants of success or failure.

We need to know the organized interest groups of the country, inasmuch as the work we are discussing involves more or less the idea of pulling together among the different agencies. Almost every local organization, we must remember, is predatory, just as much so as the wolf on the plains or the lion in the jungle. I don't like to say that about my organization and you don't like me to say it about yours, but it is true, and we might as well proceed in our work on that assumption. The community organizer who does not recognize it is going to have some disappointing experiences. In this generation we will get cooperation among organizations in most communities only to the extent that they see where affiliation with a child health project will enable them to better justify their existence in the community and also that the individuality of each organization or agency will be maintained on at least its present status. Every organization when approached by the kind of thing we are discussing here will have to be assured of that in no uncertain terms or their attitude will be either apathetic or openly hostile. Let us look forward to the time when the individualism of agencies may well be submerged and at the same time maintain their individuality. It is only by this means that the cooperative method in health work will ever become a working reality.

In the field of health work in the past we have had the philanthropic point of view. Here are these poor folks, we have said, we are going to uplift them. If you ever had that idea, it is time to forget it. The cooperative method in social work in these days is getting much further than the old philanthropic method. Community health work needs the fundamental principles that underlie the cooperative methods in which the community is taken in on a partnership basis. It recognizes that a community will go no further nor faster than the majority of the people both see and believe. It is often inconvenient. We cannot always get what we want. It means compromise very often. And we do not always like it. But it is the only basis on which constructive, permanent child health work can be done.

Then I want the organizer to know a great deal about leadership. I want her to see that leadership rests on one thing and one thing only, and that is prestige. What is the basis of leadership? Some people lead

because of wealth, some because of old family, some because of mere audacity or nerve. Others because of skill. In some it is a spirit of unselfish service. There is always something definite which gives prestige. I want the community organizer to be able to diagnose leadership. Who are the people who are leading in the community? Why is a man giving time, effort and money to a particular project? Ask these questions and diagnose the case. You may assume that he is prompted by the highest of motives. This may be true, or you may be making a mistake. There is a psychology underlying all leadership, and the community organizer must know and be able to interpret leadership on the basis of its psychology.

It is necessary to know how far a community will follow a given leader. I know a Sunday School superintendent who is an accepted leader in his line, but I do not believe the community would follow him in anything else. There is another man who leads in an annual barbecue, and is followed by a quarter of a county in spite of his being of questionable character, but that is the limit of his leadership. I know a very successful business man who was a marked failure as a Red Cross Chapter chairman. Merely because a person is an accepted leader in one thing it does not follow that people will follow his leadership in other things. Thus we cannot assume that a banker is a good leader in social work, or that a doctor is necessarily a good leader in anything outside his own field. He may be, but his leadership status in one particular avenue is no guarantee.

There are four definite steps to be taken in relation to local community leaders. These are the discovery, enlistment, development and training of people to assume local responsibilities. A leadership census of a community will reveal both the present and the potential leaders together with their characteristics in detail. A card catalogue keeps them constantly at hand when a project requiring leadership arises.

The question of enlisting leadership is not an easy one. I found myself some years ago doing it in just about the worst possible manner. I would literally "blow in" to some busy man's office. "Can I have five minutes of your time." The answer as he shuffled papers would be "Yes, yes, what is it?" Then I would tell him my story quickly, assuring him that it was not going to take much of his time, and that the demands would be really nothing, but that we wanted . . . and so on. He knew I was lying, of course, and he knew that I knew it. Most of us are inclined to go about it in that way. That is a vastly different thing from painstakingly selecting leadership on the basis of personal fitness and enlisting the prospect on the basis of a real community task, which will take both time and thought. Busy people will take time for important projects which have been well thought through.

It is not a question of getting someone to do a given task, it is a question of getting the one. "Someone" to do a job fails in about ninety-five cases out of a hundred, but "the one" almost always succeeds. Leadership enlistment must be on the basis that the job cannot go so low but what the leader will be under it. Such enlistment should be for life or for the duration of the cause. It cannot be assumed that because a person is willing to undertake a task that he knows how to do it. Many leaders are lost because they have not received the necessary development and training to do the task in hand and to do it well. This is the job of the community organizer.

Finally, the community organizer must have enthusiastic salesmanship. He must believe in his cause and present it to the public at its best. He must remember that enthusiasm kindles enthusiasm. All of the legitimate means of modern salesmanship must be used but with a degree of caution and reserve that will insure an impression of stability on the public mind. Remember that no community will go any further or faster than the majority of the people both see and believe, nor will it go further or faster than its own leaders take it. Local leaders will go no further or faster than they are informed and inspired. This is the task of the community organizer. Keep them informed and inspired that they may do the task themselves. I do not believe in the paid specialist being anything more than an organizer of local forces. Let people do the task themselves, with the community organizer pretty much in the background, and it will be found that the project will soon become indigenous to the community and will raise up its own friends to fight its battles for it.

DISCUSSION

Richard M. Smith, M.D., Assistant Professor of Child Hygiene, Harvard School of Public Health, Cambridge: I should like to emphasize one thing that should be borne in mind in training the physician, namely, that if we are going to improve the situation as it has existed in the past or as it exists today we shall have to start in the medical schools themselves. It is essential that the men who go out of the medical schools shall not only be trained with reference to diagnosis of individual patients ill with individual diseases, but shall be prepared to recognize the fact that—at least so far as children are concerned—we cannot adequately take care of the individual until we recognize the relation of the individual to the community. It is essential that our medical students be trained in the schools to a broader outlook than has been given in the past.

It is gratifying to know that this point of view is being introduced into the best medical schools of the country today, but it behooves all those of us who are interested in the problem of child health to see that such broadening out is fostered and increased, so that in the future medical men going out into the community shall realize clearly as part of their duty not only the treatment of individual sick children but the obligation of lending their influence definitely to the forces in the

community which are working toward child health, and of keeping, with reference to their patients, the point of view always of prevention as well as of cure.

Doctor Wood: In connection with what Doctor Smith has just said, I learned two or three weeks ago of an interesting experiment for the education of medical students in New York University. Miss Stella Booth, who originated the Mary Gay Theater, is Assistant Curator of the Museum of Child Hygiene of the Medical School, of which Dr. William H. Park, so well known in public health work, is curator. Miss Booth told me that they were developing a system of exhibits and of other illustrative material specially to interest the medical students in hygiene, and in her account of the undertaking she demonstrated one or two very sound points of psychology and pedagogy in the field of health education. I mention this particular fact as of interest because I honestly believe that from whichever angle we look at this program, education, one way or another, is the absolute solution of the great problem of child health, and of public health in general.

"We are setting up," said Miss Booth, "certain exhibits in sanitation, in public health, in health education, but are trying not to call them 'hygiene,' because Doctor Park and I both realize that if you display the word 'hygiene,' many people, especially the medical students, shy away from the whole thing." I rather fear that is true. Doctor Park and Miss Booth are intent on helping the medical students to get the right background.

May I call your attention to a report called "Health Education"* issued in May, 1924, by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. I believe this Report will be valuable not only for school teachers, but also for nurses and physicians. It attempts to set up the range, the essential points, of the subject matter of the material which should be included in a program of health education for the public schools and the teacher-training institutions of the country. I had the pleasure of engineering it, but a committee of twenty-seven specialists, eminent in their several fields, deserve the credit for working in wonderfully cooperative harmony to prepare the material of the Report.

This Report has tried to set up an authoritative arrangement of subject matter, but it does not pretend to give a graded course on study or a definitely determined method of instruction. It will take a great deal of research, of careful experimentation, to find out the best methods of teaching health to school children and to children of pre-school age, and I will venture to say even to the older members of the community and the parents.

* *Health Education, A Program for Public Schools and Teacher Training Institutions*. Second Edition published in 1925, by the National Education Association, 1201 Sixteenth Street, Washington, D. C.

GROUP DISCUSSION: TRAINING LEADERS FOR CHILD HEALTH WORK

1. Nurses' Section:

Presiding, MISS SOPHIE NELSON.

a. Rural Work

*MISS DORA PETERSON, R.N., Field Advisory
Nurse, Child Hygiene Division, Minnesota State
Board of Health*

b. City Work

*MISS PHYLLIS DACEY, Superintendent, Visiting
Nurse Association of Kansas City, Missouri*

Discussion:

*MISS SARA PLACE, Superintendent, Infant Wel-
fare Society, Chicago*

*MRS. EDITH BRYAN, Director, Department of
Hygiene, University of California*

*MISS CHARLOTTE MULCAHY, District Super-
visor, Bureau of Child Nursing, Trenton, New
Jersey*

*MISS HELEN FAVERLY, Staff Member, Provi-
dence District Nurses Association*

TRAINING LEADERS FOR CHILD HEALTH WORK

DORA J. PETERSON, B.N., Field Advisory Nurse, Child Hygiene Division, Board
of Health, Minneapolis, Minnesota
Rural Nurses' Work

In discussing the subject of "Training Leaders for Child Health Work," I believe it would be of interest to mention the plan for "truly rural" training which is to be offered as part of the Public Health Nursing course at the University of Minnesota. This unique plan, made to meet the needs of students who are very definitely preparing themselves to do rural public health nursing, was thought out by Miss Ruth Houlton, Superintendent of Public Health Nursing, Child Health Division of the Minnesota State Board of Health and Miss Eula Butzerin, Director of Public Health Nursing Course in the University of Minnesota. The plan includes a cooperation with the Red Cross and provides that the students spend four weeks in a county, receiving also the required school field experience during this period. The counties are to be selected on the basis of consent of the local nursing committee, opportunities offered in the field, and the success, ability, interest and previous public health training of the county nurse.

Direct supervision will be given by the Superintendent of Public Health Nursing of the State Board of Health, the American Red Cross Field Representatives, and the Director of the University Public Health Nursing course. Each supervisor, county nurse and student nurse must possess a copy of the program previous to entering the field.

One of the State supervising nurses will make a preliminary visit to the county to acquaint the county nurse with her responsibilities, and the local nursing committee with the general plan.

The first half day the county nurse or supervisor will meet with the student nurse in the office to discuss general county organization and administration, services rendered and scope of work, other cooperative agencies, records, resources, editors and roads and maps.

The remaining days of the first week are to be spent in observation which will include school nursing, the Sheppard-Towner program, tuberculosis nursing, bedside nursing, office work and so forth. The second, third and fourth weeks will be largely spent by the student in routine school work, home visiting of specified types, conducting classes, attending clinics if possible, and keeping her own records.

The student nurse is to write a report to hand to the Director of the University course in Public Health Nursing, which will include

a statistical summary and a narrative report in the form of answers to a number of questions accompanying the outline of the program.

On Friday and Saturday of the second or third week, conferences will be held with the student nurse, the county nurse and either the American Red Cross Field Representative, the Superintendent of Public Health Nursing, or the director of the Public Health Nursing course attending.

The first county having been selected and satisfactory preliminary arrangements having been made with the county nurse and her committee, this plan was put into operation in November 1924.

Because it seems to be an undisputed fact that specialized public health nursing is impracticable in rural communities, leaders in child health need to remember that rural child health work must be considered in its relation to the other activities of the rural nurse and with regard to how it may best be fitted into the county nurse's general program. In Minnesota, assistance to the nurses in planning their work has taken the form of Regional Conferences for rural public health nurses, as well as advisory visits to the nurses in their field.

Assuming that some proportion of the county nurse's time should be spent in the interest of tuberculosis, prenatal, infant, school nursing, and so forth, the question arises, "What is the relative importance of these and how much may we expect of one county nurse?" Then in turn the county nurse asks, "How can I plan my work so carefully that I may satisfy the demands made by each of these fields of nursing?" Because ideas on this subject have in the past been very vague, an effort was made to find an answer through a study of existing county nursing services, and a survey of the activities of 44 county nurses in Minnesota was made during the year 1923-1924. This was done by nurses of the Division of Child Hygiene of the State Board of Health, as they visited the nurses in their own fields.

A statement of some of the findings of this survey will clearly show that the average county nurse who serves an average area of 782 square miles and an average population of 15,591, and travels about 1000 miles by car each month, would have difficulty in adapting a city program to her territory.

The following figures were obtained from a study of each nurse's report covering this period:

1. Seventy-five per cent of these nurses had adequate preparation or training for their positions, that is, they had had a public health nursing course or successful previous experience or both. Twenty-five per cent did not have adequate preparation, that is, they had had neither a public health nursing course nor previous experience.

2. Our study of the nurse's territory showed that the average number of square miles to one nurse was 782; that the average number of people to one nurse was 15,591; that the average number of school children to one nurse was 3,073 and that the average number of schools to one nurse was 85.

3. The average annual cost of service was found to be \$2,654.00, and the average annual cost per individual, 17 cents.

4. The question as to the type of cooperation from an advisory board showed that 55 per cent of services were rendered with an active nursing committee and that 45 per cent were without.

In some counties a successful plan has been worked out by which, in addition to the regular committee members who meet with the nurse each month, representative volunteer women are appointed in outlying districts or townships. These distant members seldom are able to attend meetings, but feel it their duty to assist the nurse in her section and to report all types of health problems which occur there. Their cooperation in reporting prenatal, infant and pre-school cases is perhaps of greatest importance because of the still too prevalent opinion that these cases need no supervision except in extreme poverty or obvious illness.

5. The survey showed that 100 per cent of these nurses were provided with a car and 98 per cent with an office. Sixty-eight per cent were keeping some form of case or family record (other than school record), but only 36 per cent were provided with any clerical assistance.

6. Our survey showed that the average nurse divided her activities, with regard to time spent in each, as follows: Educational work, 69 per cent; case work, 16 per cent; records and reports, 11 per cent; meetings, 4 per cent; total, 100 per cent.

Then, too, an effort was made to determine the percentage of time the nurses spend on each of the different types of patients. The study showed that the average percentage of time spent was as follows: on maternal, including prenatal and post-partum patients, 6 per cent; on infant and pre-school children, 12 per cent; on the school child, 60 per cent; on tuberculosis nursing, 9 per cent; and on general nursing, 13 per cent.

The significant fact about these figures is that an average of 60 per cent of the nurse's time is spent on the school child. Although the county nurse could undoubtedly spend her entire time to good advantage on this type of work, there is an increasing opinion that the time spent on the school child should be reduced in order to allow more time for promoting maternal and infant projects. The 18 per cent of time spent on maternal, infant and pre-school work, although

comparatively small, is nevertheless the result of a gradual increase since the Division of Child Hygiene has been functioning under the Sheppard-Towner Act to promote this work.

In the organization and direction of the maternal and infant hygiene program in rural Minnesota by the Division of Child Hygiene of the Minnesota State Board of Health, the emphasis has in general been placed on group methods of education, namely, prenatal and infant clinics, classes for women in maternal and infant hygiene, classes for girls in mothercraft, talks, exhibits and demonstrations for health meetings, county fairs, and so forth. Plans for providing sterile obstetrical supplies for use in home deliveries are in some counties carried out by groups of local women, members of the Red Cross, or other organizations, who purchase the necessary supplies at wholesale price, make the packages, have them sterilized, and sell them at cost to the patients.

Correspondence courses have filled a distinct need in the rural program. The Correspondence Study Course in the Hygiene of Maternity and Infancy, offered through the Division of Child Hygiene of the State Board of Health, has so far reached 5,178 registrations. The Division of Child Hygiene is now considering the possibility of preparing a correspondence course on pre-school care to help fill the gap in that part of our program.

A routine plan of mailing prenatal and infant literature has been employed where long distances make home visits impossible.

TRAINING LEADERS FOR CHILD WELFARE WORK IN THE CITY

PHYLLIS M. DACEY, R.N., Superintendent, Visiting Nurse Association,
Kansas City, Missouri

In considering the training of nurses for child welfare work in the city, we must first of all take into account the nurse's background and the preparation which her training as a student nurse has given her.

To me it is appalling that so many are turned out as fully equipped graduate nurses who have had little or no experience in the care and feeding of infants and young children. Sometimes the only experience in this field which the student nurse has had during her three, or possibly two and a half years of training, has been obtained in the obstetrical department of the general hospital, unless she is fortunate enough to have trained in a hospital which is affiliated with a children's hospital. Then too, there are still too few schools of nursing which are giving their students the privilege of any training in public health nursing by means of affiliation with a School of Public Health or a Visiting Nurse Association.

Therefore it remains to us to give many of the young nurses who come to us such training as we are able to give on a Visiting Nurse staff, and thus equip them for the various types of public health work.

So many times nurses wishing to do child welfare work have come to me saying, "I love children and I am interested in child welfare work but I have had very little experience with children." How then are we to give them the preparation which they need?

I know from personal experience how difficult it is for a nurse untrained in public health nursing to find herself plunged directly into child welfare work even though she may have had splendid training and experience in children's nursing.

To my mind there is no preliminary training which can take the place of general district work on a Visiting Nurse staff. In this way the new nurse learns her first lessons in public health nursing by means of that which she knows so well—bedside nursing. In this type of work she becomes familiar with the fundamental principles of public health and all that it means. She learns the proper approach to the family and how to use her own powers of observation; she begins to develop her ability as a teacher, and she learns to consider the family as a whole rather than the patient alone.

This type of nursing, perhaps more than any other, gives her the opportunity to learn the resources of the city and to become acquainted

with other organizations whose work is so closely related to her own, and whose cooperation and help she so often needs to solve the problems which she meets every day.

Her training during these first few months is by no means confined entirely to field work. Along with it she must have definite instruction by means of class work, lectures, demonstrations and personal instruction by the supervisor who is guiding her first steps as a public health nurse. She must be given the opportunity to visit clinics, child welfare stations, institutions and organizations so that she may become thoroughly familiar with them.

If it is possible for a nurse to have from two to six months' experience in general visiting nursing she will make a far better child welfare nurse than she would have made without it, and she herself will not feel that she has been suddenly dropped into the unknown, nor will she become so easily discouraged.

Whereas in all lines of public health the nurse must necessarily be a teacher, this is especially true in child welfare work. Now that our efforts are spent towards keeping the baby well rather than curing him when he is ill, the nurse must be able to impart to the mother the knowledge which she herself has.

In no other field, perhaps, is there more need for an infinite amount of patience, because for every mother who responds to the nurse's instruction, there are apparently at least a dozen who do not. Often, however, the nurse is unexpectedly rewarded when a mother with whom she may have struggled for a year or two of the first baby's life without any apparent result, comes to her of her own accord for advice in caring for the second baby. The mother who said to a nurse, "the children and I watch for you as most people watch for the sunshine," made the nurse feel by that rare compliment that there was nothing more worth while than the work which she was doing, and that she was to that family the help which she wanted to be and which every well-qualified child welfare nurse may be to the families which she visits.

In the development of a nurse as a leader in child welfare work there is no one who can be of more assistance to her than the physician with whom she is associated. By his skill, sympathy and kindly interest in all that concerns the baby and his mother, she receives real inspiration and from him she learns a tremendous amount in the care and feeding of children.

There must necessarily be perfect team work between the physician and nurse if we are to accomplish the best results in the educational work of a child welfare program.

In discussing this subject I have not mentioned the training in child welfare which may be obtained by means of a University course in Public Health, but I have confined myself to the situation as it applies to us in Kansas City where we have no opportunity for University training.

The Visiting Nurse Association of Kansas City supplies nurses to fifteen organizations engaged in public health work and of these eight are devoted to child welfare. Besides these the Visiting Nurse Association conducts two Child Welfare Stations for colored babies.

All these nurses have been trained on our staff especially for child welfare work, and every nurse assigned to such work must have had at least two months' preliminary training in general visiting nursing, and when possible we prefer that she should have had a longer experience. Before making her responsible for a district of her own she is allowed to spend some time with an experienced child welfare nurse, so that her approach to the work may be gradual.

If we are to have nurses as real leaders in child welfare let us give them the very best foundation we can while they are staff nurses. Let us give them by practical experience, if possible, a better understanding of all branches of public health work, so that they may by this very understanding do better work in their chosen field.

From the staff of the present must come many of our leaders of the future and we cannot give them too careful a preparation.

The Chair: The papers we have heard, dealing with the main subject of Training Leaders for Child Health Work, are now open to discussion from the floor. We very much want to get the ideas from the visiting nurses so that we may come to some consensus of opinion about what are the things essential to child welfare work.

DISCUSSION

Miss Sara Place, Superintendent of the Infant Welfare Society, Chicago: Of the many students who come to us, with a view to becoming members of our staff, there are a great number who have had no training-school preparation for the work. Time after time, nurses have come, in fact, with little or no training of any kind who have wanted to do infant welfare work in our organization. We have not required that a nurse shall have had any previous public health experience. We believe that such organizations as ours should have training courses for public health nurses; and in this training we try to give them the closest possible supervision.

I believe that in the planning of an educational course today some thought is being given to this point and some such additional preliminary training is being provided for student nurses. But we know that some of the best training schools give little or no preparation for public health work, though such training is absolutely essential. It is also true that little or no preparation is given in the children's wards. And it is certain that some knowledge of the normal health of children will

have to be given through a definite course of instruction. We have four students on our staff, we feel that is all we can take at one time.

The Chair: Is there a regular course of instruction that you give them?

Miss Place: When a student comes to us she is placed, either for full or for part of the time with an experienced nurse. Unfortunately, we do not have a regular course.

The Chair: Is anyone at this meeting who represents an association which requires preliminary instruction in public health work?

Miss Edith S. Bryan, Director, Department of Hygiene, University of California, Berkeley: We have in our state a Department of Public Health. We have a state association for public health. And any nurse that is going to be paid by the municipal and county funds must pass a state examination. In order to take this examination, the nurse must have had either a course in public health nursing, or must have had training on a public health nursing staff, or on a regular training staff; or she must have done similar work under the supervision of an individual nurse.

The Chair: Who decides what is a regular, well-trained staff?

Miss Bryan: The Public Health Department. As a matter of fact, there are very many associations that are accepted. The State Board of Education has just made a ruling that a nurse must have had training before she can go into the school work. In our counties, the school nurse includes in her work pre-school, child welfare conferences, and so forth.

The Chair: Is anyone working out a regular course of instruction for the new nurse?

Miss Dacey: One of the first requirements in our course is that the nurse be personally fitted for this work. We find constantly nurses who do splendid bedside work, who would never make health teachers. I recall one nurse who was really unhappy in her child welfare work. When enquiry was made as to the cause of her unhappiness and non-success, she replied: "I can't talk!" She could not talk with the mothers. A change was made. Now she is doing fine general district work and making a success of it.

We are giving nurses from four to six months in the training work before they are put into public health fields. We are now trying to give them some experience in all lines of public health nursing.

The Chair: Is there anyone present who has an educational program outlined for the new nurses before entering child welfare or public health work?

Miss Charlotte Mulcahy, District Supervisor, Bureau of Child Nursing, Trenton, New Jersey: The normal school in Trenton is cooperating with the State Department of Health, insofar as they are allowing one of our supervisors to do the school nursing in the normal school.

We have a baby welfare station in the normal school itself. We have twelve district supervisors each with one or two counties.

The Chair: I would like very much to hear from Miss Faverly.

Miss Helen Faverly, Staff member of the Providence District Nurses Association: In Providence we are doing special work under one general head. We have a general service, a child welfare service, and other special services. We do not require public health training. We do get students, eight at a time, two from each of four training schools. They do not go through the special services at once, but do general work for possibly the first two months they are with us. They have the benefit of lectures from the supervisors in the special services, however, during

that time and are working in contact with those doing that work. Then we have a supervisor who has charge of the work, and who has a wide experience. At the lectures and in connection with them, we have close supervision. When the student comes on first, she is not at once taken into the special service. She goes into the general service, where, in all probability, she will stay for six months. During that time she gets a thorough training in the general work. New nurses, if they have not been with us as students, take the regular course that is required of the students in the special services, and are given thorough instruction. We give lectures in the history of the child welfare work, and then go into its development in the different countries, the needs of different places, and the way these needs have been met. We pay special attention to the ways of meeting the needs of our own city.

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GROUP DISCUSSION: TRAINING LEADERS FOR CHILD HEALTH WORK (*Continued*)

2. Community Organizers' Section:

Presiding, E. L. MORGAN.

a. Rural Work

*FLORENCE BROWN SHERBON, M.D., Director
of the Bureau, Kansas Bureau of Child Research,
University of Kansas*

Discussion:

*F. W. BLACKMAR, Ph.D., Professor of Sociology,
University of Kansas*

*J. O. RANKIN, Professor of Rural Economics,
University of Nebraska.*

b. City Work

*WILLIAM J. FRENCH, M.D., Director, Child
Health Demonstration, Fargo, North Dakota*

Discussion:

*W. C. EWING, Secretary, Philadelphia Child
Health Society*

*JOHN S. SINCLAIR, M.D., Medical Director, Ba-
bies' Hospital, Philadelphia*

MISS KEELEY, Polk County, Missouri

*H. E. HAMBLIN, M.D., Health Officer, Tampa,
Florida*

WALTER H. BROWN, M.D., Mansfield, Ohio

PREPARATION AND TRAINING OF RURAL COMMUNITY ORGANIZERS IN CHILD HEALTH WORK

FLORENCE BROWN SHERBON, M.D., Director Kansas Bureau of Child Research, University of Kansas, Lawrence, Kansas

STATEMENT: Since child health means basic health conditions in home, school, and community, organization for child health is in a sense synonymous with organization for community health and will be so used in this paper.

1. He should be born and reared in the country or at least have actually resided in the country for a sufficient time to have established a mental residence there, so to speak. There is a difference amounting to a real class consciousness between a group of people born and reared in the country and a group born and reared in the city. The whole background of mental imagery; habit complex; traditions and values are so radically different in the two instances that clear and intimate understanding each of the other's life and problems is not to be expected.

Unless the individual who elects to do social work in the country shall have had at least a part of his rearing in the country, he will in most instances remain, in a very real sense, an outsider both in his attitude and reception.

2. He should have a high appreciation of country life. The individual who elects to do rural social work of any type should be imbued with a spirit, not of the missionary who carries to the benighted a message born of conscious spiritual superiority, but rather he should be filled with a spirit of appreciation of the importance, beauty, and dignity of country life. He must seek his work in this field because here is the place above all others where he wants to be. In any type of social work he who condescends or patronizes is lost. This is true even in slum work. It is particularly to be remembered that the agricultural family does not suffer from inferiority complex. The members of the rural family are and should be conscious of their strategic value to the world, and the successful rural health worker must also share this sense of their personal worth. It will be impossible for him to do this unless he too has felt the smart of frost and sun; the intimate comradeship of plant and animal life; the deep fatigue and the brief, deep sleep of the harvest; the sweet hunger for plain, strong food; the meditative calm of the long winter evening by the fire, with its accompanying dread of the cold plunge into an unwarmed bed; the daily glory of the summer sunrise, and a hundred other experiences known only to the rural dweller. It is the individual who goes from this rural

life to the school where he acquires social perspective and scientific information coming back with a new appreciation of the country who makes a real contribution to the life of his chosen people.

3. He must bring mental and physical vigor, initiative, resourcefulness, and imagination.

Rural child health problems present a social, geographical, and often a political complex, which must be analyzed and handled by a single worker usually, whereas, in a city it would be handled by various specialized groups. Therefore, the rural worker must be gifted with versatility of preparation and imagination, but versatility touched with the fire of enthusiasm and centering in a definite purpose.

In addition to, or along with preparation as public health nurses, home demonstration agents, clergymen, health officers, superintendents of county welfare boards, or whatever other specific task may bring the community organizer into the rural district, all workers who attack the rural health proposition will need certain basic items of preparation in common. These will include:

1. A broad and practical knowledge of the modern science of personal health.

The worker who attempts to raise the health level of a community will succeed in the measure in which he is able to sell a definite, effective personal health regimen to every individual in the community. Lacking a definite, enthusiastic, personal concept of positive health and its full meaning and importance, his efforts at health organization will be vague and unconvincing. He must have ever before him the ideal of the sound, serene mind in the sound and well-developed body, and constantly strive to make every individual strongly desire this ideal for himself and his family.

To do this with success the health organizer must be familiar with:

- (a) The newer knowledge of nutrition.
- (b) The newer physical education program.
- (c) The newer mental hygiene program.
- (d) The newer knowledge of heredity, sex hygiene, and so forth.

2. A broad and practical knowledge of the modern community health program.

Given a knowledge of the factors which determine the health of the individual, the health workers' next problem is so to adjust conditions that the individual may meet no insuperable difficulties in achieving positive health for himself and his household. This may involve radical changes in home and school sanitation, quarantine-enforcement, official organization, and so forth. Among other things he will need to know how to organize clinics and conferences; how to introduce health

work into the schools, and so forth. Therefore, our community organizer will need to be familiar with:

- (a) The modern science of disease prevention.
- (b) The modern science of home and community sanitation as applied to rural conditions.
- (c) The principles and practice of modern rural school sanitation.
- (d) Modern community health organization, as applied to the rural group.

3. A broad and practical knowledge of modern social science.

Our worker may now be assumed to have a clear ideal and enough information to know exactly what he wants to put over, but he will still need to give serious consideration to the manner in which he is going to "get it across" to his people. He will need to know all the rules of the great game of human relationships. He must know how to secure effective group activity. He must know how to make the child an emissary of health to the home; how to identify and concentrate upon the crucial factors in given community problems; how to seize upon the proper forces for remedial effort; how to play up the psychology of self-expression and give everybody a job. He must know how to build from the known to the unknown; from the felt interest toward a larger ideal.

To achieve this modest aim, our rural child health worker will need to have:

- (a) A knowledge of rural community structure and organization.
- (b) A familiarity with survey technic.
- (c) Familiarity with the psychology of the family group.
- (d) Sufficient familiarity with educational psychology and group psychology to enable him to call out self-expression and leadership and to enable him to know how to delegate tasks and effectively apportion work.
- (e) Some familiarity with modern economic theory and rural finance.

The world is surely on its way toward the achievement of a broad, general science (with no end of specific branches) of positive health. Gradually basic constructive courses are edging into our curricula, and little by little are edging into places of importance. Practically every progressive college and university now offers courses in rural sociology, although most departments of sociology still devote the major part of their energies to social pathologies. Courses, departments, and even schools of public health are arising in increasing numbers.

It is still not easy to state how and where the would-be rural health worker may find the preparation assembled in one given place to meet

his varied needs. As far as I am informed, it will be necessary for him to set up a clear concept of his needs and get his training where he can.

The fundamentals in organic and social sciences he should be able to acquire in any standard college or university. He will need good, strong, up-to-date science courses, however, and should select his college and his courses with great care. Present-day science is a cataclysmic force, which is changing our religious, moral, and cosmic concepts with almost explosive suddenness. The world is being submerged and overwhelmed by it, and he who does not scramble for a higher mental and spiritual foothold will presently find himself engulfed in outworn tenets and swept into stagnant eddies and bayous.

In most schools for the training of specific types of rural social workers it is now possible to obtain training in school hygiene, public health, rural social science, and something of economic science.

Along with this basic instruction should go a generous amount of experience in practical field work of as many kinds as possible, in order to train the worker to meet situations and to know people.

Conclusion: The world has come into a new realization of the worth of the great class of people who feed the earth. The gift of health which modern science holds out to all is equally the right of the country and the city. It is not in condescension but in justice that the country child should have an "equal chance for equal health."

The standard for the rural community organizer for child health work cannot be placed too high. It has need to be even higher than that for the city because of the remoteness of the rural worker from expert advice and the support of boards and officials.

It is the function of groups such as are here assembled to set standards. It is to be hoped that something definite and helpful will crystallize out of the discussion in this session.

DISCUSSION

F. W. Blackmar, Ph.D., Professor of Sociology, University of Kansas: How is one to get this great preparation? It seems to me that Dr. Sherbon has outlined a program more severe than that required of the medical or the ministerial or the legal profession in its breadth, scope and understanding. But I am certain that I agree with her in emphasizing the tremendous importance of this community work in rural districts.

The social worker needs a large baptism of common sense. You will find that more essential in dealing with farmers and farmers' children and rural conditions than anything that the sociologist in the university can give you.

The question of humanizing knowledge is really taking a strong hold on the universities and especially the departments relating to social science. So the sociological Departments simply say: we must have a laboratory, and that laboratory is human society.

The state universities and the universities of this country are giving a wide range of study and then connecting up with health departments, boards of health, and connecting up with biology, medicine and so on, so that this training can be had there.

J. O. Rankin, Professor of Rural Economics, University of Nebraska: I should like to agree rather strongly with Professor Blackmar that the requirements laid down for the training of this medical-social-worker are rather severe. Severe discipline is necessary for the training of those who are to be medical people, and especially if they are to be not merely individual doctors but community doctors with good knowledge of social structures and functions and of the laws that are in operation.

I am very glad, being a rural sociologist in particular, to find a Director of a Child Research Bureau who recognizes the rural phase of the work as the writer of this paper distinctly does. I am glad that she has put down so definite, so concise a curriculum and program of work. Perhaps the most difficult of all is to state how we will sell to the country people, this idea of the need for rural health. We are a little too much like the proverbial ostrich, and I say that not with any lack of charity because I am one of them and always have been, a little bit too much inclined to feel we have such perfectly fresh air, fresh food and so much of it, such perfect conditions in every particular that we do not need any health inspection in the school nor anything of that sort; that we are very well off in that particular if we can only get the economic foundation, economic advancement that we want. So that if I should add anything to the curriculum laid down it would be perhaps that ability to sell the idea to the people, whether it be through courses in journalism, or whether it be through training along some other line. In some way or other we must find ways to sell our ideas or program. The country people really need them but the country doesn't always realize its needs.

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TRAINING LEADERS FOR CHILD HEALTH WORK IN THE CITY

WILLIAM J. FRENCH, M.D., Director, Child Health Demonstration, Fargo,
North Dakota

In order to discuss our subject intelligently there must be, to start with, an appreciation of what child health work consists of, and some idea of its scope. Broadly, anything which affects the physical, mental or moral condition of the child can be considered under the general heading Child Health. Thus, proper control and supervision of water supplies, milk supply and distribution, sewage disposal, control of contagious disease, supervision of active tuberculosis cases and contacts, and so forth, all concern physical child health as well as adult health. Public Health is dependent upon child health. The best index of public health conditions in a community is the health of its children.

Mental health is likewise dependent upon certain rather definite things. For, outside of the inherited capabilities of the child, in which both the community and the family have had a part, its mental state, as represented by its ability to adjust itself to its social environment, is dependent upon the training given it at home and at school. In like manner, the child's moral health is dependent upon both the moral standard of the home and that of the community.

To sum up, then, we may say that while public health is dependent upon child health, the latter is in turn dependent on the one hand upon the completeness of the public health program and the care and intelligence with which it is administered, the character of the educational facilities offered and the moral tone of the community, and, on the other, to living conditions within the family unit.

Here we may ask the question, does not the success of the public health program in a community, the character of the community's educational facilities and its moral tone, each in turn depend upon the attitude of the family units towards these things? Undoubtedly, to a very large extent. The child health problem must be attacked, then, from two angles. First and most important is the attainment of right living on the part of the family group, and second, proper living (functioning) on the part of the community as a whole. These two interact and are interdependent.

From what groups must child health leaders come? There are really six: physicians, nurses, teachers, social workers, spiritual advisors, and the citizens of the community who may not belong to any of these professional groups but who may be said to be the representatives of the family group.

Outside of the physicians, which group is the most important? It is hard to say. Each has a peculiar but vital part to play, and the truth is that, unless each recognizes this fact and is willing to develop its own particular and extensive fields and to recognize the vital necessity of the others and cooperate with them, progress must be delayed. It is this recognition of the place each group has to fill in the child health program, with a willingness to stick to its particular part and a desire to blend all these activities into a composite whole, that is essential in such a program. This is one of the first truths prospective leaders must learn.

I have purposely excepted the physicians because they of all others must be the persons on whom the main responsibility for the success of a child health program must fall. They are, or should be, the leaders of leaders. This is a health program, you must remember. Its very foundation is preventive medicine. But preventive medicine to be effective must not only embrace those measures which aim to eliminate disease as such, but must also concern itself with all those things which aim to eliminate mental and moral ill health—in other words, the family right living.

How, then, are we to train these various groups?

Training with all of them must begin early and must be of a positive, not a negative character.

The physician must be taught while he is yet a medical student, yes, even as far back as his pre-medical courses. He must be taught, whether he expects to specialize in public health or not, the importance of prevention of disease and the best methods of prevention—the elements, certainly, of public health. He must be taught to look upon the child as the future citizen, a member of a family group and the nucleus of a future family group. He must be taught that not only this child's future physical condition but also his reactions as a member of the community, are dependent upon proper food, avoidance of fatigue, proper elimination and general sanitation, fresh air and play, and water inside and out, as well as upon periodic physical examinations and the avoidance of disease. He must be taught that the community will more and more be looking to him for expert advice and guidance in these things and that other leaders in a child health program must and will take their cue largely from him.

This sounds like a large order. It need not be if medical schools will provide teachers with a social point of view, who, by correlation, can teach most of these things while instructing students in biology, physiology, anatomy, practice, or what not. Until medical schools do give their students a social point of view, and an adequate, positive

idea of preventive medicine, they are not turning out the type of physician the world really needs today.

But what of the men who are already in practice? They, too, must be trained to take their place as leaders. This can be done by bringing them in touch with other physicians who are doing this work and who appreciate its importance, by persuading them to take postgraduate courses or by following the Rankin plan which consists in bringing postgraduate courses to them. Or by supplying them with literature, or by making a demonstration in the community as is being done by the Commonwealth Fund Demonstrations in Fargo and elsewhere. This last is one of the most effective methods. Such demonstrations bring to the attention of the local physicians the latest and best in child health work and preventive medicine. They also educate the citizens of the community to demand that the local physicians inform themselves in regard to these methods and give them, the citizens, the benefit thereof.

The next group, nurses, have for a long time been leaders in child health programs and have frequently been the influence in a community that has caused child health work to be started. A natural love for children and a desire to see them well and happy are two essentials for child health leadership with which nurses are usually endowed. In addition to possessing these qualifications for leadership, nurses should be given during their senior year in training at least six months' field work attached to a child health program, or to a public health program which makes special provision for child health, or postgraduate training involving such field work. Becoming attached to some piece of work which will give them necessary field experience amounts to the same thing.

It is hoped that the day is not far distant when teachers will be taught in the normal school the essentials of health and the importance as well as the advantages of teaching positive health. There is no place where leadership is so much needed as in the schools and there is no one who can exercise more influence for good than the teacher. She can exercise her influence directly by home visiting, at the same time obtaining a knowledge of home conditions, or indirectly by influencing the pupils who in turn influence the home. But she can only inadequately exercise either of these influences unless she has in addition to some knowledge of pedagogy, including health subject matter, a knowledge also of biology, human and comparative anatomy and physiology, hygiene and public health. She must have this background, and when she has it she is in a position to lead. What a wonderful

team she, the physician and nurse can make, and how very high they can elevate the standard of health and right living!

No one should attempt to lead from the social service end until he or she has had proper training in social service methods either in a school for that purpose or under the apprenticeship of recognized authorities. Properly trained social workers recognize the place each group must play not only in a child health but in any other social program.

Next is the spiritual advisor. What of him? Has he an important part? Yes, one of the most important if he and the man on the street will only realize it. Spirituality is a necessity in any program for any leader. Dogma is less important. How are we to get our pastors and priests to see this and to assume the leadership they should exercise; how are we to get them to see that not only is "cleanliness next to godliness," but that proper nutrition, avoidance of fatigue, out-of-doors play and fresh air generally—in other words, right living for the individual child as well as the family—are equally so? I believe the best way is to demonstrate what can be done with family groups. When the spiritual advisor has seen the improvement that takes place he will be a convert, and often a leader. Dr. Noble of Pennsylvania has devised a scheme for holding children's conferences in churches which might be adopted for cities as well as rural communities.

So also with the ordinary citizen, the representative of the family group. He, too, must be shown and the best way to show him is through his children. If you can get these children young enough and through their teachers persuade them that it is the thing to do to live right, they can and will exert a powerful influence on their parents. I have in mind especially a man in Fargo, who, through the influence of a small son, changed his mode of living to such an extent that not only did his personal health and family happiness increase but also his interests so that he became an investigator, and will undoubtedly take a prominent part in the future of child health in that city.

There are still many cities in the United States which are without trained leaders in child health work. What method should they pursue? An individual or group of individuals should be obtained, financed through community resources, both public and private, or through arrangements with some outside group or organization, who, after making a survey of the local situation, can proceed to outline plans and put into operation a child health program. Such an individual or group must have the active interest and support of a local committee which is representative of all private groups of importance—business men, social and philanthropic groups, and so forth—and of the city govern-

ment as well. As the program progresses, it will be found that various individuals will become sufficiently interested to make a point of studying methods and results. These will eventually become leaders.

One of the best ways to fire the interest of these people and develop it, is to attack the adult population through the children themselves. Successful work carried on with infants and pre-school children will often do this but the group par excellence is the school child group. By work with them, both direct and through the teachers (health education) whereby the children are made to take a positive interest in health and right living, much can be done in educating leaders. The Fargo man mentioned previously in this paper is one instance. The priest in charge of one of the parochial schools in Fargo is another. In the interest of correction of defects he has made a house to house canvass of his parish with the result that nearly 100 per cent corrections have been obtained. These two men, with others similarly interested, will always be leaders in any child health program in Fargo, and while they themselves are not actually trained, perhaps, to carry out the details of a complete program, they will see to it that the community employs the necessary trained personnel.

Others in the community become leaders because, through some prominence or official position, they have been asked to become members of committees having to do with child health programs; still others because their position in the community throws them intimately in contact with the program actually in operation. City officials, the health officer, the superintendent of schools, school principals, teachers, and so forth, represent this group. In the former case the responsibilities of their committee position cause many to take sufficient interest to investigate methods and results. Investigation breeds further interest. In the other case, intimate contacts oft repeated or extending over considerable periods of time, develop both interest and leadership. Giving members of each group something to do involving definite responsibility is of vital importance.

DISCUSSION

William C. Ewing, Managing Director and Secretary, Philadelphia Child Health Society: I think that one of the most helpful teachings of modern Psychology is that everybody acts as a member of a group; that nobody in civilized society ever acts as a single individual unaffected by the other people in his group. If we can get group activity back of the child health work we can accomplish things that never could be accomplished by a small group of technically qualified people. While we are here in Kansas City we have an opportunity to see the organization of a group which is rarely organized with any effectiveness. Here is a group of 3000 volunteer workers who are interested in getting the little children into fit con-

dition. Out of the 18,000 pre-school children in this city, 15,000 are examined every year. Did any of the rest of you ever have an experience like that? Do you know how many trained workers they have to do this work? Four. This work was started with the Parent-Teacher Association. Now there is some similar organization in almost every city which can be made a starting point. What an opportunity for educational work is possible with the groups of Parent-Teacher Associations or Mother Clubs, or Father Clubs or Church Clubs, getting together to solve the problem you put up to them: what are you to do with these children of yours. Here is a group of doctors, here is another group of workers, who are willing to supply the technical knowledge. Now it is your problem to put their knowledge and their skill to the service of these children. I believe we have to work every element in the community in order to do effective child health work.

John S. Sinclair, M.D., Medical Director Babies' Hospital, Philadelphia, Pennsylvania: First of all, this work must deal with the family as a unit and must include every member of the family group if it is to be one hundred per cent effective. The only way to make this work effective and sound and really useful is to make it intensive to select an area small enough so that you can cover it. Take a city block as a beginning and clear it up. Then take a second and third block. Clean up the ward in which those blocks are before you try to clear up anything outside of that ward.

The Chair: I wonder whether, in connection with this matter of the rural situation, we should not recognize that the chief cause for rural health lagging so behind urban may lie in the fact our small towns and open country have not yet had quite as many layers of education spread over them as the average urban community has. Of course it is in the city where we can get at people the easiest. We can spread a layer of education a good bit more quickly and a good bit more easily than we can in the open country. My conviction about this is that the farmer is ready and able to pay for public health as soon as he is convinced. Let us see the task of selling health in the country as not being primarily different from selling health in the city.

In dealing with the country population there is this one point that comes to my mind,—in the average city we deal with the small submerged class in many instances. Now when we come to deal with the average farm family we have a different situation. We have been surprised many times. Our students come back and say, "I couldn't get into that farmer's house there. The conditions aren't good there but they wouldn't let me in and I couldn't get in." I was very much for the family. In all our social work in the open country we need to recognize the fact we are dealing with a vastly different psychology. That is not the same psychology we will get with the group we are dealing with in the city, because the ownership factor enters into it as it doesn't with the people with whom we do social work in the city.

Dr. Ada E. Schweitzer, Director of Division of Infant and Child Hygiene, State Board of Health, Indiana: We have been allowed to go into the Agricultural school and tell them about our child health projects, and to set before them the desirability of good health as a thing in itself and as a factor affecting their efficiency in the community. We usually work in the county and then have a round-up, as we call it, in the city or county seat, the larger towns in the community.

Recently we tried to organize one of the most backward counties in the state for child health club work. When the workers went into that county we said to them, "Now, you can't go into this county and start work as you have done in other places. You can't work with community groups but with the people individually.

There are no groups. These people are suspicious of strangers and don't meet them well because they have never had to meet strangers. They have lived in isolated groups so long they don't know there is anything better than what they have and they are likely to feel that what they have is better than anything anybody else can offer them. You will have to present your program in such a way that they will feel that they are doing you a favor by accepting it, not that you are doing them a favor by taking it in." And I said further, "You will have to be one of these people while you are in the community. There must be no superiority on your part. You will have to go in there and talk with them and live with them." Our staff workers did that very thing. They went into the communities on horseback and chopped kindling wood, carried water, helped with the various duties about the farm and in various ways gained the confidence of the people and were able to organize a very fine piece of work.

The Chair: Very glad to get this report of actual happenings. That is a matter I think is always good to bring out at a meeting of this kind. We are apt to get a little far from the ground sometimes.

Miss Keeley, County Agent, Polk County, Missouri: In selling the idea of Health Work the most important friend we have is the county editor, for the real reason he has more authority than we have. If he will print our "stuff," to speak technically, the people will believe it more because he prints it than because we say it. To get him to print it is a most important way of bringing it to the people. When we have a meeting we give him the names of every person who attends that meeting for that helps him to get subscriptions. Then he will do the printing.

H. E. Hamblin, M.D., Health Officer, Tampa, Florida: I was very glad the Doctor used that phrase "the baptism of common sense" because I never knew how to get above the words "applied common sense." Psychology and applied common sense is what the worker needs in the field. Country people are about like town people for most town people have been country people.

Saw mill work is different from the hardware store man when you want money. You must show the saw mill man the monetary end of the game and he will put up the money.

If you can go into the home and talk to the mother and get her interested enough to ask you questions you are on good ground, but if she doesn't want to ask questions, well, I back out of her house and get right away. The next time I come in from the kitchen door. I have a little speech I deliver and the subject is, "The Trail to Your Kitchen Door." She gets interested in that. When I go to the Ministerial Alliance I have the same subject but I talk to them about the "Home of the Soul," which is the body.

If any of you people are younger in the work than some of us don't get the idea into your head you must know all you have been told about psychology. Just get a little. Just go on and use what the doctor called, "a baptism of common sense."

I went down to Florida when I was a boy and I went right out into the country and lived among the people there, voted among them, and now I know the Florida cracker and know all about him. I know him in the country and know him in the town. Since the automobiles, it is a whole lot easier to tell city people out in the country than it is to tell country people in town. But learn your people and use your applied common sense, and don't crowd them. Let them take after you and kind of follow, and they will call you back. They will get interested provided you let them.

Dr. Walter H. Brown, Mansfield, Ohio: I had not meant to say a word, but we have had a most striking example of the thing I wanted to say just now. I want to see every community worker have all the technical knowledge Dr. Sherbon or the other sociologists have talked about but I haven't found any way yet by which we can discover and reproduce what Dr. Hamblin has just given us as the natural, innate common sense. That means the leadership that made America before we had colleges and before we had trainers in social work.

Now we want all the training we are talking about, we want just as much as we can have, but we have to find some way by which after our trainer or our community worker has acquired all this knowledge that we can submerge it so far below the surface into his sub-conscious mind that nobody will ever know that it is there, except as it shows in his leadership as he goes out and does the thing about which Dr. Hamblin has told you, and which he didn't get in colleges but which was handed down to him. And that will be the only way in which we will be able to take this technical knowledge particularly to our rural people.

With all our learning let us find some way to develop this common sense that is needed so much in social and health workers.

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GROUP DISCUSSION: TRAINING LEADERS FOR CHILD HEALTH WORK (*Continued*)

3. Teachers' Section:

Presiding, MISS EMMA DOLFINGER, Director of Health Education Division, American Child Health Association

a. Teaching Health Through Nature Study

MISS MILDRED SYKES, Assistant Supervisor of Nature Study, Los Angeles City School District, California

Discussion:

MISS MARY E. MURPHY, Acting Director, Elizabeth McCormick Memorial Fund, Chicago

Miss Anna Richardson, Ph.D., Dean, Division of Home Economics, Iowa State College

Mr. Phillips, State Teachers' College, Maryville, Missouri

b. Preparation of the Teacher

MISS ELMA ROOD, R.N., Director of Health Education, Child Health Demonstration, Mansfield, Ohio



Teachers' Section

Presiding: Miss Emma Dolfinger, Director of Health Education Division, American Child Health Association:

Professor Turner stated that it was necessary in training teachers that they should have a knowledge of subject matter, and of methods, obtained from observation and practice, and a knowledge and experience of organization and administration. He emphasized the importance of practical teaching under proper supervision of a course worked out for each teacher, in order that each leader might have the particular kind of training necessary for her, and a realization of the importance of personality and personal qualifications. We are considering the best ways of improving teacher leadership, with the idea that the preparation is based on what a teacher has to do, and on what are some of her responsibilities.

The first paper is by Miss Sykes.

THE TEACHING OF HEALTH THROUGH NATURE-STUDY

MILDRED SYKES, Assistant Supervisor of Nature-Study, Los Angeles, California

We have only to give ourselves the opportunity to get out of doors, take a breath of pure air, catch a wild sound and watch some wild creature move mysteriously, to feel the primitive in us coming to the surface. All at once our attention is alert, our senses keen, our interest vivid. No more universally appealing subject can be found than that of nature-study. So nature-study offers an admirable approach to a desired end—a means of teaching health to one particularly interesting animal, the human boy or girl.

The method of the summer vacation camp is the most natural and the most ideal. Campercraft and outdoor nature-study are obviously healthful pursuits and are not only in themselves wholesome activities but they create a strong desire for physical fitness. The physical advantages of health are never more acutely realized than in a primitive existence. So, after an understanding of health rules is acquired, a conscientious following of these rules and the building up of bodily vigor is ardently inspired.

The occasion for this ideal method of health-teaching, however, is very limited. For the greater share of children in a city, a summer camp is an impossibility. A comparatively small number learn to take advantage of the city parks or to utilize them in a way constructive of health. There is much greater opportunity during the school year to reach a vastly larger group of children through the regular school

course in nature-study, which offers innumerable ways in which health may be taught directly and indirectly.

Every school room should have some living, growing animal or plant dependent upon the children for food and water. This thing may vary in attractiveness and poetry from a hollow potato with a wet sponge replacing its insides to a yellow canary in a shining brass cage. Whatever it is, it must require feeding, watering, cleaning, care and attention.

A caterpillar exhibits most spectacularly the effect of food, cleanliness, fresh air, sunshine or the lack of these. He obstinately refuses to eat anything except his proper food, and the more abundant and fresh his food, the fatter he grows. If he be given double quantities or extra care, he responds immediately. This performance teaches emphatically the necessity of food for growth and impresses the observer that regularity and quality are important.

Pure experimentation might be undesirable, perhaps, but occasionally unexpected opportunities occur. In a city school a room had been raising silk caterpillars, the children in turn taking them home over the week-ends to care for them and give them fresh mulberry leaves. One Friday a small boy took them home and placed them inside a fresh cigar box with the cover down. All but a few of the largest caterpillars died, and the survivors were limp and weak when brought to school the following Monday. These were given fresh food, a fresh box and fresh air, and finally recovered. Tobacco, nicotine and nicotine poisoning were carefully discussed, and it was suggested that one caterpillar be given increasing amounts of nicotine and that he be "taught to smoke." It was at length decided best to avoid risks, as there were so few survivors, and all caterpillars were denied tobacco.

The treatment of wounds on an injured pet may demonstrate the cleansing, dressing and healing of a wound. Any skin cut or scratch is noted and washed with antiseptic. A clean wound and an infected wound may be compared and explained. The children are taught to keep pets away from the face and to wash the hands after playing with pets.

In one school the Annual Pet Show was a deliberate plan to teach the children cleanliness in handling their pets and to give them some practical experience in bathing, feeding and treating them. It was a forlornly dirty district where pets were astonishingly plentiful. For days preceding the show, the applications upon dogs of kerosene, mange cure and laundry soap were unmistakably manifest. Afterward one child was observed consoling her dog for not securing a blue ribbon with the words, "Next year I'll scrub you gooder." But usually the

impetus for bathing netted more than one bath a year.

Bacteria can become as positive a reality to children, with their abundant imaginations, as flies or rattlesnakes. After the children have collected bacteria from milk bottles, lavatories, flies, fingers and tongues, the culture of these bacteria and the killing of them becomes a fascinating and significant game. In this way a "bacteriological sense" is instilled which results in improved habits at the drinking fountain, in the lavatories, and at luncheon.

In the Los Angeles city schools, following an intensive study of the life history of the fly in every grade at the same time, came a "Swat the Fly" campaign. Scores were kept for the number of breeding places discovered, numbers trapped, for new trap models and for the most effective posters. The enthusiasm and response were wonderful. Nature-study maps were made of the neighborhood about schools, and the inter-relation between stables, trees, water, flies, garden truck and sunshine studied. One well which had "better water than city water" was condemned by a health officer. This was eventually understood and approved by the children, after a study of their own maps.

Conservation of natural resources applies to the health of the child. When he finds that his health is of economic importance, he appreciates its value the more. This conservation may be applied objectively. In studying the teeth of the rodent, the child finds that the rodent's front teeth grow constantly and that by rubbing against one another they are kept sharp and in good condition. If harm befalls the teeth, the rodent grows ill-conditioned and soon dies. So the child sees the value of good teeth and realizes that the care of his own is important.

Occasionally a dead animal will be brought in to the nature-study teacher. The body may be skinned in order to reveal bruises or bullet holes so that an assumption as to the cause of death may be made. A dissection of the organs always proves exciting when accompanied by an explanation of function and an application to human anatomy.

Nature-study trips to the seashore or the mountains are often the first of their kind to many hundreds of city children. These field trips open up a new world of enjoyment in tide-pools, salt spray, mountain trails and mountain streams, which has a permanent recreational effect. Guarding against poisonous plants and animals and a knowledge of treating their ill effects is readily acquired in preparation for these trips.

Collecting natural objects, such as rocks, butterflies and wild flowers, leads to a healthful activity which affords exercise in fresh air and yields a permanent interest. The study of natural life in the city parks or zoos acquaints the child with more recreational possibilities.

It is well to plan to have these trips include the luncheon hour, so that the child may receive help in purchasing wholesome food from the distracting array offered at lunch counters and in the concessions of the public parks. A study of the definite working of nature's laws and an appreciation of the fact that they are not to be compromised should accomplish this with the help of some lessons upon what a balanced meal comprises.

The existence of sex among animals becomes matter-of-fact with a wholesome treatment. A mother guinea pig which is soon to give birth to a family of little ones is treated with particular gentleness and is given carefully selected foods. She is guarded from frights and is given every consideration.

The most fundamentally important way in which nature-study teaches health is through the cultivation of the scientific attitude. When a child finds that he does not get warts from handling a toad, he may begin to question whether a hair from a horse's tail will actually turn into a snake if kept in a jar of water. He begins to reason things out for himself from then on. Observing cause and effect leads to an inquiring attitude which discourages belief in quacks and superstitions. This is developing a healthful attitude of mind as well as a healthy body.

(It would be interesting for those present to shape a questionnaire to send to nature study teachers to discover the many health habits formed and the individual methods used in teaching health through nature study.)

DISCUSSION

Miss Dolfinger: Does anyone know of any public school course of study where any definite effort is made to teach facts through nature study? When we consider what the opportunities are for teaching fundamental processes concerned with growth, by watching development of plant seeds, for instance, how many experiments there are by which you can humanly and reasonably demonstrate development, it seems most unfortunate that we do not include that type of thing more definitely in the curriculum. Our normal schools do not always provide teachers with any such opportunity. Courses in biology at universities do not always ensure a teacher's knowing how to handle the matter with fourth or fifth grade children so as to bring out underlying life principles. If we are going to get life principles or health knowledge, through the medium of nature study, it looks as if we would have to go to the schools, from the elementary through the normal schools, to biology, bacteriology, and other such courses, reorganizing the material very definitely, so that the facts may be presented to the children as a key to life principles.

I should like to hear what are found to be the chief obstacles to getting health teaching through nature study. Has anyone observed any efforts which would throw light on that question?

Miss Mary E. Murphy, Acting Director, Elizabeth McCormick Memorial Fund: You, Miss Dolfinger, have given the chief answer on that question, I think. Most of us, whether teaching or not, have felt that we have not had sufficient training—the chief obstacle is just that: we, for the most part, are not trained in science. Most of us do not know enough about science fundamentally. There are at this time all sorts of efforts at popularizing science, but that is not the solution. There are some schools where they demonstrate certain facts in nutrition by feeding rats. The rats thrive when given certain foods; but the same food will not give the same result if coffee, for instance, is added to it. That is a sort of thing that can be done in the way of demonstration.

Miss Dolfinger: There is the danger of carrying such a demonstration too far or not far enough, if the teacher has not had sufficient training in science.

Miss Anna Richardson, Ph.D., Dean, Division of Home Economics, Iowa State College, Ames, Iowa: We are training young women for practical reactions to life. We are attempting to correlate our science so as to make some of these applications. First we have had to get over to the science departments that we wanted our girls to apply biology to life. Then that idea had to be got over to the science faculties. There are conferences between us and the science faculties as to what science should be included or admitted. They are interested, and willing to help in our program.

Mr. Phillips, State Teachers College, Maryville, Missouri: The problem is in bringing to child level the subject we want to get over. It is absolutely necessary to train the teacher in the method of teaching health. That we have signally failed to do. We have to remember that the instruction given to the student in college has been along adult lines. In any other branch, we give training for the subject matter and after that, training in the presentation of that subject matter. It is my belief that there will be but little respect for the question of health teaching until we use the same procedure for it that we do for other branches. Therefore I advocate most strongly the teaching of methods for the presentation of health in all its ramifications. It is all right to give the boys and girls a knowledge and an interest in nature, but why not say we are teaching health and using nature study in correlation?

Miss Dolfinger: I would subscribe to that if the nature study were sounder—and it ought to be. There is always the danger that this nature study may not be well enough organized, may not be well presented. Perhaps if we said we were using nature study to teach health we should get better biological material.

Miss Rood will now present a somewhat different aspect of the subject of preparation of the teacher. Miss Rood has been training young people in the County Normal classes, and she is going to give us some of her experiences in increasing the efficiency of those young people.

PREPARATION OF THE TEACHER

ELMA BOOD, B.N., Director of Health Education, Child Health Demonstration,
Mansfield, Ohio

Health Education for teachers in training in Mansfield was established in connection with the county normal class which prepares teachers for the one-room rural school. These young students go out as leaders in their small communities, working with very little assistance and shouldering most of the responsibility for the school life of the rural child.

What is the goal toward which this preparation in health should aim?

For many years teachers have had fairly clearly in mind the ideals toward which they are working in the "three Rs"—knowledge and skill having perhaps had a place in the foreground. It remains, however, to make concrete an ideal toward which to work in health, an ideal which is simple enough for children, teachers, fathers, and mothers to understand and of such a character that it is possible of attainment by a reasonable number of children.

Mansfield, being situated in a rural area is quite familiar with Blue Ribbon cows and pigs, and with prize winning stock of other varieties. Our problem has been to translate this "Blue Ribbon" ideal into something that can apply in a human way to the growing boy and girl, and into something which will make itself felt as a practical objective to all our teachers.

In order to bring this ideal within the range of the normal school student's experience and from this experience to create enthusiasm for a similar ideal in children, we aim to develop Blue Ribbon Teachers. To raise each student to within 10 per cent of his normal weight, to secure corrections for all defects, to insure the voluntary practice of good health habits, and to inculcate the knowledge which is necessary as a basis for teaching health to children will be the objective of the year in health education.

To realize this ideal in the school room, various avenues of approach insure a network of associations. The ideal then becomes a spirit which permeates the whole school atmosphere, and which finds its subtle way into geography, history, agriculture, and general science, cropping out continually in tangible form in the school environment and in activities carried on by the children.

It is then the aim of the normal school to demonstrate these associations in its entire curriculum just as we hope our students will carry them out later in their own schools.

Consequently the normal school endeavors to emphasize constantly in its own program the ways in which the attitudes and ideals of the child may be developed. Outstanding among the healthful influences constantly utilized are, (1) the personal example of the teacher, (2) the environment of the student, (3) practices of the school, (4) direct health teaching, (5) direct correlations, and last but not least (6) incidental correlations.

One of the most important influences in the school room is the teacher's own personal example and spirit. If she is fortunate enough to look the picture of health she has in her hands untold power to influence the child's attitude. If she lives it, as evidenced by an abundance of energy, good nature, a ready smile and a hearty laugh she adds tremendously to that power. If also her attitude toward the children is kind, considerate, concerned when a child is not well, glad when he gains, keen to see any departure from the normal, she has trebled her influence in developing the desired attitudes in her class room.

Very important as means of developing our ideal are the surroundings of our students, consequently environmental conditions are made the subject of critical observation. For instance a thermometer chart being kept this year is calling attention to the importance of air temperature as a factor in influencing health. The lighting of the class room, the sanitary care given daily to the building, and the water supply, are all matters of vital concern.

It is also of great importance for young teachers to realize that environmental conditions are not physical alone, but that a cheerful atmosphere in which approval, praise, and commendation are prominent factors, makes for an environment, the whole spirit of which helps children grow. Here again, the personal example and spirit of the teacher determine the spirit of her school.

Of far reaching influence in the development of health attitudes are the daily practices of the school room, especially those in which the students take an active part and in which they exercise originality and initiative. The regular morning inspection at 8:30 as a part of training for good citizenship, the health examinations conducted for the students, short rest periods during the day, the removal of all out door wraps in the school room are all practices whose influence can be seen in our rural schools. Active play at intermissions is another point. When the normal school students go out on the playground and supervise the play of children in their practice groups, they not only become familiar with good methods of supervision but at the same time get the recreation that they need themselves.

The direct health teaching, which is now, after two years of

demonstration, being taken over by the director of the class, follows in general the plans for the rural schools. In primary grades, emphasis is placed on doing things with simple explanations and reasons; in the intermediate grades on explanations of health habits sufficient to satisfy the children's growing curiosity; and in the upper grades on the knowledge children must have in order to protect themselves, to protect others, and to help them be good citizens. In all grades the development of favorable mental attitudes is an outstanding aim.

Direct correlations are opportunities seen readily, of which advantage may be easily taken. For instance, an art period may be used for making a health poster, an English period for writing a composition on the current health topic, an arithmetic lesson for computing weight scores. There is danger, however, in overdoing the direct correlation and getting the kind of reaction that a visitor did upon entering a school and finding one small boy sitting idle while all the others were occupied. Upon being asked if he did not like to do what the others were doing, the reply was, "No! Cause every time I do anything, I got to write about it after." Direct correlations must be used in moderation and only where the child sees the primary purpose.

Incidental correlations, although placed last, are far from least in importance in influencing health attitudes. These are the correlations that already exist naturally, but need to be brought out at the opportune time. They are particularly valuable because they are constantly occurring in the day's program, and afford innumerable opportunities for securing emotional response. They are often subtle and require skillful handling to be effective. They are also often associated with some pleasurable experience which leaves a lasting impression on the child's mind. They can be made in a very short time—often a word or two, the teacher's expression, a well directed question or remark serves to bring out the point.

Incidental correlations, while of such vital importance, can seldom be exhibited in tangible form, their results being measured by growth of spirit.

Let me illustrate. A primary teacher was giving a crayon lesson on the daisy. The children made funny little pictures of flowers with long stems growing in tall green grass. At the close of the lesson, a number of children were asked to show their pictures to the class. Of course there were a great variety of daisies. Some were tall and straight, some were drooping, their heads hanging over dejectedly. The children thought some of the flowers needed water. They knew what happened when mother forgot to water her plants. They decided they liked the ones that stood straight best. At recess time the teacher said to

the children, "How many will be sure to remember about the tall straight daisies when you go out for recess?" Every hand went up, and every child had a drink upon passing the fountain. I noticed, however, that the teacher was conveniently near by as the children passed out. The correlation had been made so naturally and so skillfully that the children entered spontaneously into the play spirit.

Another such example occurred in the puppet show of Little Red Riding Hood staged by a primary group. The children were practicing the scene where the wolf calls on the grandmother. The little boy who was arranging the scenery, hesitated about the placing of grandmother's bed. The teacher turned to the children and said, "I wonder where would be the best place to put grandmother's bed?" One child answered quickly, "Oh I know, by the window because she's sick, and has to have lots of air." A smile of satisfaction from the class, an approving attitude on the part of the teacher and the correlation had been made.

Incidental correlations to the busy rural teacher are invaluable avenues to health attitudes. One such teacher exclaimed, after examples like these had been cited in an institute, "This has opened my eyes and I see now how with a little practice health can come in at many points."

Incidental correlations especially need emphasis in the normal school program. As the teacher grows in spirit, as she makes a definite effort to see and grasp these subtle opportunities, and as she studies the effect of various methods upon her class, incidental correlations increase in number and value.

The final measure of their effectiveness will be the extent to which they influence the attitudes of the students.

If all of these methods are constantly in evidence in the normal school classroom, extending also into the practice school, the students realize their importance not only from their own personal experiences but also from their tremendous effect upon the health ideals of children.

DISCUSSION

Miss Dolfinger: Could you tell us about the cup contest for blue ribbon children?

Miss Rood: Last year the Rotary Club in Mansfield gave seven silver trophies for the rural schools; one each to the six villages competing among themselves, and one to the Mansfield school that accomplished most along health lines.

This year an attempt was made to score the teacher's work directly with points she could use in the classroom and was responsible for in the classroom, putting in as the climax the increase in percentage of blue ribbon children. The teacher evidently

DISCUSSION

will be scored on the other points, but it goes under the head of increase of percentage of blue ribbon children.

The one-room rural school teacher is asked to score herself, giving certain points for things like morning inspection, cleanliness of room, health teaching in classroom, etc. In the villages and in the city a certain amount of scoring is being done by the school administrator, because the individual room teacher could not be held responsible for some things, and it is a good thing to get some of the responsibility into the hands of the principals; for instance the inspection of the building is the direct responsibility of the superintendent of the school. He scores so many points for sanitation, for instance. So everyone tries hard. Whatever the teacher reports in comes into her score. In the spring, when the reports are checked up, and it is shown which school will have the trophy cup, it will probably be necessary to visit the schools to see the spirit of the place. The contest corresponds with the contest of the rural schools, so perhaps there will be no one who will wield quite so large an influence as the nurse, as she will know the spirit of the school.

The children know that if the county superintendent comes and wants to score, he can.

There is this question of training leaders. Dr. Morgan yesterday said the leader must know sociology and community organization. That must also be included in the point of view of the teacher. Nowadays we are teaching teachers to put children in possession of their faculties by making the best of situations. The sooner we come to think of health teaching as being an opportunity for getting children to take hold of these things and practise them for themselves, the sooner we shall have teachers who will be good leaders.

Miss Dolfinger: In Holyoke, Smith, and Bryn Mawr, they have very interesting activities, but there are very few places where they have any complete program.*

Speaker: In Ohio University health instruction is carried on in connection with health examinations.

Miss Dolfinger: It is reported that since this began in the University attendance at the doctor's office to seek advice before illness comes has gone up by leaps and bounds.

Miss Strachan: Dr. McCracken of Vassar College has offered a silver cup to the class making the most points—points which go for outdoor sports.

Speaker, Oklahoma Agricultural and Mechanical College: We wondered what we could do to stimulate interest in health in the high schools. We began to say that we had our prize pigs, our prize cows, our prize colts; why not have prize girls. Why not have our prize girl? We got her. She was rated 98 per cent by the senior girls of the Home Economics School. She had to live up to certain rules. The brother of this girl came up to my office and said, "Do you know you made her follow the rules we lay down for the breeding of our pigs?" It was rather a shock to them to think that if one applied the rules they made for the animals they could help themselves.

*Now Vassar College has a new Department of Euthenics which may develop a new comprehensive health program.

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**JOINT MEETING WITH KANSAS CITY
ANNUAL FALL CLINICAL CONFER-
ENCE AND MEDICAL ASSOCIATION
OF THE SOUTHWEST**

PUBLIC HEALTH PROGRAM

*Presiding, E. H. LINDLEY, Chancellor, The University
of Kansas, Lawrence, Kansas*

The Doctor of the Future

*GEORGE E. VINCENT, Ph.D., President, the
Rockefeller Foundation, New York City*

**Internationalization of Child Health and Its Sig-
nificance**

SALLY LUCAS JEAN

THE DOCTOR OF THE FUTURE

GEORGE E. VINCENT, Ph.D., President of the Rockefeller Foundation

Let me at the outset disavow any idea of forecasting definitely or dogmatically the future of the medical profession. One can hope only to enumerate conditions and tendencies of the present and to raise rather than to settle questions as to the probable effects of these things in the coming years.

The outlook, of course, varies with different countries. Racial, economic, social and political conditions affect medical service in a variety of ways. There can be no uniformity of development. Kinds of doctors and services appropriate to widely diversified environment will appear in different parts of the world. This address will deal with the outlook for such countries as the United States and Canada.

The rapid increase of scientific medical knowledge, experience and technical resources is causing obvious changes. Medical education now costs a great deal more in time and money. The modern doctor is dependent as never before on laboratory, hospital and complicated and costly means of diagnosis and treatment. The specialist has become a necessity. No one person can control the whole range of knowledge and technic.

The present situation with regard to American population groups and the kinds of medical service they are receiving may be roughly described as follows: The mass of the population are, perhaps 75 to 80 per cent, treated by general practitioners who have limited technical appliances, little or no specialization of skill, and slight relation to medical services organized in hospitals, dispensaries and clinics. The rich and well-to-do, perhaps 5 per cent, receive attention from specialists who depend primarily upon their own individual equipment, have little connection with institutional medicine, but provide a high degree of specialized skill. The poor, perhaps 15 to 20 per cent, are under the charge of organized practice, that is, doctors who have access to institutional equipment, offer a high degree of specialization and are fairly well connected with hospital, dispensary and health center services.

There are forces at work which will gradually modify this state of things. Thus, preventive medicine in reducing the amount of sickness is limiting curative practice; in many areas typhoid fever, which used to be prevalent, is rare; malaria is yielding to comprehensive measures of control. Other communicable diseases which used to afford a good deal of practice are being steadily reduced in amount.

Again, the high cost of sickness is causing changes. There is a growing demand that this cost be distributed over large population

groups. The principle of insurance against sickness is being applied in different ways. In some countries the state system of compulsory insurance has been adopted. Elsewhere, hospital associations and sick benefit societies are, for a small weekly or monthly fee, guaranteeing free care in case of illness. Industrial groups are providing medical hospital care in return for small sums deducted from the wages of employees and supplemented by contributions from the companies. Such developments which are multiplying rapidly have a bearing upon the future of the medical profession.

Changed conditions affect the geographical distribution of physicians. The unwillingness of doctors to settle in the country and a tendency towards concentration in the towns and cities is unmistakable. The countryside is, on the whole, failing to replace the pioneer practitioners of an earlier generation. The truth is that men with modern training are not attracted to rural practice. They are not satisfied with the income. They want hospital connections, professional comradeship and, for their families, the opportunities of education, society and recreation which towns and cities afford. There is no reason to suppose that a cheaper, more "practical" kind of medical education would turn out doctors who would be willing to go to the country.

There is another factor which must be reckoned with. A credulous public opinion permits the spread of cults, quackeries and fanaticisms which increase the difficulties of well-trained and conscientious physicians. Modern medicine depends for its success upon a public that understands and appreciates. It must be admitted that the medical profession is not wholly blameless for the gullible state of the public mind. Neglect of the psychic side of medicine, failure to help educate individuals and the public, narrowly conceived professional policies, shortcomings in the knowledge, skill or integrity of some doctors have had their part in producing the present situation. The chief responsibility, however, rests with the whole educational and social system. It is reflected not only in the popular attitude towards medicine but towards science generally and in all forms of thinking and feeling.

Out of conditions such as those that have been enumerated no one type of doctor will, of course, emerge in the future. There are now pretty clearly recognized kinds of physicians. They fall into four groups: (1) the professorial doctor, who teaches and investigates; (2) the specialist; (3) the socialized or full-time salaried doctor; and (4) the individual, independent general practitioner.

The teachers and investigators will always form an element relatively small in numbers, but of vital importance. They will give more and more time to research and instruction. While a few will give all

their time to such duties, the larger number will continue private consultations which will have a bearing on their teaching and investigative work.

The specialist is an inevitable outcome of the growth in knowledge, experience and technic. In all probability there will be a steady increase in the numbers and in the prestige of doctors of this kind. They are likely to be better organized and to have private clinics and hospitals, although for the time being the tendency towards group practice seems to have received a check. Standards of specialized efficiency are likely to be formulated and increasingly enforced. Voluntary professional associations will do something. University degrees will do more. State requirements may ultimately prescribe standards when these have been worked out by the profession and by university medical schools. There may be delay, but the time will surely come when only fully qualified and certified surgeons, for example, will be legally permitted to perform major operations.

The institutional salaried doctor has come to stay. The Army, the Navy, hospitals, dispensaries, asylums, industries, school systems, insurance companies are multiplying the demand for men and women who will devote themselves exclusively to social service on a salaried basis. Already a considerable percentage of the medical profession sustains a whole or a part-time relation to institutions.

In spite of the growth of the other types, the individual general practitioners constitute by far the largest group of doctors, perhaps 75 per cent of all. Except in emergencies the great mass of the population look to the general practitioner. When the word doctor is mentioned, it is he who comes to the mind of the average citizen.

The well-trained, properly equipped, experienced general practitioner of ability, character, personality, is a fundamentally valuable person. He is a good diagnostician. He sees his patient as a whole. He knows his peculiarities and circumstances. He can decide when to refer him to a specialist and when to protect him against the very real danger which is threatened by a narrowly specialized point of view. He cheers and encourages or warns and commands. He is not only a physician, but a friend and counsellor. He is a good citizen and an asset to the community. Too much cannot be said in praise of the individual general practitioner of the best type.

The problem of the American doctor in the future largely resolves itself into this: Can the general practitioner be reproduced on a high level of efficiency and can he survive under the conditions which he is likely to face in the future? These questions involve at once medical education and the organization of medical service.

There is widespread dissatisfaction with the medical curriculum. Critics say that it is too crowded, too theoretical, that the student is "spoon fed," given too little opportunity to think for himself and to develop initiative. There is too much tendency to have in mind the training of medical scientists and specialists rather than of the general practitioner. Reformers are insisting upon a thoroughgoing revision, upon a reduction in kinds and amounts of instruction, upon a clear differentiation between undergraduate training which should aim at turning out the general practitioner and graduate training which should be reserved for the medical scientist and the specialist.

The general practitioner will survive only on the terms upon which any social functionary holds his own. He must gain social esteem or prestige and be able to make a living. Many assert that the general practitioner is doomed to disappear, that his opportunities are being constantly restricted so that in the future he will be unable to win confidence and a livelihood.

It may be admitted that the general practitioner as now equipped and related to the profession faces serious and probably increasingly difficult handicaps. He is over-shadowed by the prestige of the specialist. He cannot as an individual afford the cost of modern equipment and technical resources. In the case of perhaps half of the general practitioners there is no genuine hospital connection which affords opportunity for continued education and professional stimulus. The growth of institutional and of preventive medicine is constantly encroaching upon the ordinary fields of curative medicine.

The disappearance of the general practitioner would be a serious loss. Such an outcome is not to be contemplated without deep concern. The underlying American philosophy of individualism with its insistence upon independence, initiative and ambition seems to be embodied in the general practitioner. Are there ways in which he may readjust himself to the situation? He may hope to survive if he will submit to a measure of organization and team-play in the cooperative use of laboratories and other resources, in meeting the demand for spreading costs of sickness over large groups through readjusted forms of compensation and especially if he will become a practitioner of preventive medicine.

The doctor may make a place for himself as a counsellor of health. Personal hygiene will always remain the largest part of a public health program. After the environment has been made sanitary and communicable disease subjected to the maximum control, there will remain the vast field of personal health for which no organized public functionaries can assume responsibility. If the general practitioner will recognize this opportunity, if medical schools will prepare him for the

service, if the community will recognize his value in this new relationship, an inspiring career of opportunity and usefulness will open up before him. This will mean, however, a gradual change of attitude, an increasing interest in the normal, a study of the effects upon health of diet, exercise, mental attitudes, recreation, family and social life. All the finest qualities which have made the general practitioner successful in the past may be trained to even greater account in the future.

In view of all these contingencies, a confident prediction would be hazardous. The public demand for efficient service, for special skill, for reduced costs, is likely to increase. Gradually—very gradually—public intelligence and discrimination may improve. It is to be hoped that in time people will give more than lip service to the ideal of prevention. The day may come when men will treat their bodies almost as wisely as they do their motor cars.

In such circumstances a better and more economical organization of medical service will be inevitable. No thoughtful person can welcome the extension of state medicine beyond the legitimate and necessary field of public health activity. But, if private initiative and voluntary co-operation fail, it may be impossible to resist the demand for governmental intervention. This has happened in Germany and England, in backward colonial possessions and even in new European states. A persistent social need will demand satisfaction if not in one way, then in another.

The medical profession, then, has a heavy responsibility and an inspiring opportunity. Will it recognize the tendencies of to-day and the demands of to-morrow? Will it take the long view, the socially conscious attitude? Will it see that the best service must be made available to the great masses of the people on terms that they can afford to meet, that no medical mechanism can efficiently replace skilful and sympathetic human care and guidance, that prevention of disease must be more and more a dominant motive, that the general practitioner, if he is to survive, must be readjusted to new times, trained, esteemed and rewarded as a vital factor in the medicine of the future?

You will rightly reply that the responsibility rests only in part on the medical profession. You will properly ask, "Will family life, schools, colleges, universities, the press, the platform, social standards, public opinion offer an environment in which well-trained, wisely organized and high-minded doctors can do their work honestly and efficiently, protected against ignorance, prejudice and fanaticism? Yes, it is a social problem which involves our whole civilization. To analyze it is not to solve it: We can only hope that clearer vision may kindle imagination and strengthen resolution.

INTERNATIONALIZATION OF CHILD HEALTH AND ITS SIGNIFICANCE

SALLY LUCAS JEAN

Waves of patriotism awakened by war, calamity, or National achievement have through the centuries brought man to a high point of willingness to serve his country, sacrificing his all for the good of the whole. In the intervals he becomes absorbed in the problems of his personal life, leaving National affairs largely to the politician and statesmen—supporting official machinery, it is true, but without much thought as to the relationship of the national policies and resultant actions upon himself or his family.

International relationships are even further removed from him, and it is only in time of war, plague, pestilence, or famine that he considers his nearness to the neighbors across the sea, or across the boundary which separates his country from the others.

The present daily and even hourly intercourse between nations resulting from modern transportation and communication has, however, brought to the attention of even the most socially indifferent individual the interdependence of all peoples. There is, for instance, a dawning consciousness that the slogan launched in this country by Dr. S. Josephine Baker during the early days of the infant welfare movement, to the effect that "Your child is only as safe as your neighbor's child" may well be developed now to read, "Your child is only as safe as the children of other nations."

The importance of strong, healthy children is generally accepted today by all governments, though the efforts to secure this end are in proportion to the social development of the people, the officials in power being dependent upon the will of the masses.

The problem resolves itself into one of education of the people, and as this is somewhat dependent upon governmental action, the vicious circle seems almost too strong to be broken. But if we trace the advance of the child health movement through the last few years, we cannot but realize that we in these United States have demonstrated to some extent the possibility of educating the people, and thus securing official action. In a degree this is also true in all countries.

The objection has frequently been offered by those who are strong believers in the so-called States' rights' theory that government of all matters pertaining to the personal welfare of the people should be in the hands of State authorities, but we must admit in the face of this objection, that forty States have ratified the Sheppard-Towner Amend-

ment, and the eight which have failed to do so have either passed State legislation for the same purpose, or are considering such action.

The people of the United States have been educated to believe that their government can at least guide them in developing ways and means for saving the lives of their mothers and babies. This measure is not thought by even the most ardent advocates to be ideal, but all thoughtful people are willing to leave the development from this first step in the hands of the officials in the Federal Children's Bureau.

The significance of this action is patent to all. We have demonstrated our belief and faith in the principle of giving every mother and baby a chance for health, whether born in one section of the country or another. Our neighborhood is growing!

We now have under consideration a bill for a department of education which aims to give the same sort of governmental assistance to all States as the Sheppard-Towner Act offers.

Familiar objections are raised by unfriendly voices, and perhaps wisely, but we may well pause and consider the statement of Charl Williams, Field Secretary of the National Education Association, that "we are still in the 'covered wagon' stage of our public schools." We now use high-powered automobiles and up-to-date pullman trains to pass from one section of the country to another, but we are still content to allow our children to attend schools of a type built in the covered wagon stage—indeed, in many instances, to use buildings erected during that period—and to have our children taught by untrained teachers.

A Federal department of education will not automatically produce modern buildings and well-trained teachers, but it will offer a standard of achievement and serve as a guide to the States.

The appropriation which the Bill carries and which has been freely attacked may be considered as unreasonably large, but it is, oh, so little for this rich country of ours. Your speaker believes that the best hope for a good all-around school health program lies in the passage of this Bill of the National Education Association.

There is a similar awakening occurring in all parts of the world. Even India, with its unknown death rate and an infant mortality which is estimated at 90 per cent of births, has had Child Welfare Days during this year, with gay posters displayed throughout the country for the purpose of interesting mothers in the modern care of infants. China has a new magazine devoted to health in which a large place is given to the importance of educating the teachers in health. Belgium has an excellent program for puericulture and, though limited, one of the best established systems known for distributing milk for babies. Under the Commission for the Relief of Belgium, a program has been developed for health teaching in the schools, and according to the last reports,

97,724 children in 1,013 public and parochial schools were "Playing the Health Game" with the approval of the Government.

France, the first country to develop infant welfare stations, has not kept pace with some of the other countries, but has advanced tremendously during the past few years. School health work in France, as well as in Italy, has been a reflection of the American developments. This, however, is true in a measure of all countries.

During the war the Junior Red Cross executives launched a program in the schools of Czecho-Slovakia which insured health teaching to all children. This spread into Austria, and through adjustments, has since been made to meet the needs of after-war days. The programs are flourishing.

Russia with its chaos sent a representative to this country during the past year who not only studied our health and social activities but our educational systems, with the idea of establishing in Russia the best systems of "paidology," a term of Stanley Hall's which the Russian representative said meant to him the best in pediatrics and the best in education combined.

England publishes the best annual report of school medical service known, this being familiarly termed by those interested in this subject as their "bible." It is not necessary to say to this audience that the infant mortality in England is lower than our own, though one wonders how much longer such will be the case with the taxation necessarily imposed upon the people by the war.

In South America there is an enormous awakening which can only be attributed to the march of civilization. One cannot but be impressed by the earnest desire of the women of these countries to raise the health standard of all children, and the determination to be satisfied only with having secured for the children of their land an opportunity for health and happiness.

A recently published book entitled, *Child Health Education*, by Dr. Mary Hannan of South Africa, says in the introduction, "How I wish each Province of the Union of South Africa would send a Normal Student to be trained in the United States. A two-year course would cost about £250 per year, and would surely be worth while for the rearing of a healthy, happy, and prosperous nation of South Africans." She goes on to say, "I have been actuated to prepare these hand books for the use of South African parents and teachers by personally realizing the benefits and advantages America experiences."

This expresses the opinion of many educators from foreign countries—they have benefited personally, and want the teachers of their country to participate in the privileges they have enjoyed.

You are all familiar with the exchange of graduate students and professors which has done so much to bring about a better understanding of international problems, but very few people know of the exchange of teachers which has been established between England and Canada. This is now becoming a more general practice and it cannot be too strongly endorsed and encouraged. The teachers of the world have in their hands the possibility of fermenting discord and hate, or understanding and love between all the peoples of the nations.

During the most formative period of life, children spend five or more hours a day with their teachers who are largely responsible for their beliefs, their attitudes, and their habits. It is not possible to secure the corps of well-trained, experienced teachers needed in any country, but it is possible to give at least a small group of teachers each year the opportunity for broadening their experience and vision. The responsibility for making health laws, for enforcing them, for the establishment of health consciousness, is in the hands of the children in the schools of the world. Let us be very sure that we are giving to their teachers every opportunity for growth so that they may in turn wisely instruct in health matters as well as in history and civics, interpreting fairly "other men of other lands."

Dean Gildersleeve said upon her return from the International Federation Conference of University Women recently held at Christiania, Norway, that "it had become obvious to intelligent minds that if our civilization was to avoid complete wreck, it was absolutely necessary that nations should learn to understand each other and learn to live helpfully as citizens of the world."

At Edinburgh, Scotland, there will occur next July the second meeting of the World Federation of Education Associations. Here class room teachers and administrators will gather together from all parts of the world, as was the case at the first world conference on education which was held in San Francisco in 1923.

Though the program for the coming conference has not been completed, President Augustus O. Thomas, of Maine, proposes to give a real place to health education. This section, you may remember, was conducted at San Francisco through the cooperation of the American Child Health Association with delegates from fifty-two nations.

In this country we may be weary of conferences, exhibits, and public meetings, but as a young Scotch teacher said of the Wembley Exhibit which England has stimulated her colonists, as well as those living nearby to attend, "oh, it is a grand sight, and gives one so much to teach the wee lads and lassies." Visualizing this we can imagine what a step in advance it would be if every year at least one teacher

from each State were sent officially to travel in a foreign country, the selection of the individual based not only upon scholastic degrees, but upon ability to teach and to inspire children and their parents, thus increasing the group of torch-bearers.

Education in health can advance only as education as a whole advances. To insure good health teaching, we must assure well-informed, well-trained, stimulating teachers and administrators.

A recent report by the Chief of School Hygiene Service in Greece, announces that the systematic teaching of health is being undertaken in all schools through lectures, films, and publications on health matters. The Fly, Trachoma, Scarlatina, are some of the subjects mentioned.

It is interesting to compare this period with that of early Greek civilization, when though in some sections only strong, healthy babies were allowed to live and little was known of disease or its treatment, the youth of Greece were more nearly perfect in their physical development than has ever been the case in any country since.

What did the ancient Greeks give their boys and girls that brought this result?

The most important factor seems to have been a high ideal of physical development with a love and appreciation of beauty. Plato taught—first health, then beauty, then skill and strength in physical exercises. In his Republic we find this sentence, "Let our artists be those who are gifted to discern the true nature of the beautiful and graceful; then will our youth dwell in a land of health, amid fair sights and sounds, and receive the good in everything."

There is a tendency today to place before children images of health and beauty, but we are still somewhat inclined to interpret films and pamphlets describing the various diseases as health teaching.

The Youth movement, originated in Europe, has assumed such proportions that it must be considered as a great potential force for Internationalization and health.

In Germany alone 150 magazines and papers are devoted to the interests of this group, and there is a membership of 4,000,000 young people between the ages of 18 and 30. In going over this literature one is impressed by the desire for self-expression, and a yearning for beauty. A strong sense of the inter-relation between youths of all ages is evident, and a determination to end war. The development of a healthy body is recognized as necessary to happiness, though one questions the desirability of permitting young people of both sexes to become clotheless wanderers together for days at a time as do thousands all over Europe for the purpose of securing their goal of health.

The Youth Movement in America announces—

“A CALL FOR A WAR-FREE WORLD.

“Everywhere today Youth is in revolt. The boys and girls who suffered and still suffer as a result of the world war are joining hands across the frontiers and boldly commencing to build up a new civilization.

“The Failure of the Older Generation.

“It is well for the future that Youth has imagination enough to conceive of a war-free world, and faith and courage to work for its realization.

“Our elders plunged us into a world of war. They have no adequate plans for building a world of Peace. Their half-hearted schemes will not satisfy the bold enthusiasm of Youth.

“Governments still spend their millions on equipping armies, navies and air fleets.

“Governments still spend their millions on scientific research—not for the benefit of mankind, but for its destruction.

“Everywhere is chaos, misery and despair.

“War is Not Inevitable.

“Youth calls upon Mankind to have the courage to end these things and to step forward boldly towards a war-free world.

“Youth says war is NOT inevitable.

“Youth says war CAN be abolished.

“War can be abolished by inspiring men and women to work in the spirit of service instead of in the spirit of greed, and, by educating men and women to establish an international order expressing this fellowship ideal.”

This striving to establish a better world is most encouraging, but indicates a failure on the part of adults to convince the youth of the different countries that present methods are good. They know we lacked vision in not setting a higher ideal for them. They want a war-free, healthy world and propose to use their own way of attaining it. Who can say it is right or wrong? Our methods have not been so successful that we can unquestionably advocate them.

The Youth movement indicates that the younger generation are struggling toward a higher ideal of physical development as well as spiritual development—if belief in the practical application of the brotherhood of man can be so considered. Science has given the world much since the days of ancient Greece and new discoveries are rapidly being made.

Application of this knowledge with a high ideal of complete individual development and an appreciation of beauty can result in the superman of whom we all dream. Health is the universal language understood by all peoples, desired by all. The whole world is ready to follow the lead of America in health matters. Let us not rest until we share with all nations our abundance of knowledge.

Gabriela Mistral, the poet and educator of Chile, said in a recent visit to this country,

“The more or less purely immediate political relations of today must be replaced by a spiritual movement in which the cooperation of a great state will not be looked upon as the domination of the weak by the strong, but as the immensely human helpfulness of a great and prosperous nation which has found itself and which has already reached maturity, toward other states which are slowly and painfully striving toward the same goals.”

This, then, is my vision of our present obligations—With the existing urge on the part of the youth of the World and with America’s potential leadership let us now, at least, seize this specific and concrete opportunity of sending our teachers to international conferences which develop new ideals and strengthen the bonds between the educators of every land through teacher exchange and every other feasible method.

With this ideal in our hearts we can look forward to a world of healthy children who will grow into adults believing in the good purpose of the peoples of other nations.

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PROBLEMS OF LATE CHILDHOOD AND EARLY ADOLESCENCE

*Presiding, FRANK C. NEFF, M.D., Kansas City,
Missouri*

1. Physical Aspects

*BORDEN S. VEEDER, M.D., Professor of Clinical
Pediatrics, Washington University, St. Louis,
Missouri*

2. Mental Aspects

*SIDNEY I. SCHWAB, M.D., Professor of Neurol-
ogy, Washington University, St. Louis, Missouri*

3. Educational Aspects

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Discussion:

*CHARLES W. BRADLEY, Head Master, Kansas
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PHYSICAL ASPECTS OF EARLY ADOLESCENCE

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Adolescence, or the period of youth, is usually defined as the period of the life cycle between puberty and maturity. From a physical standpoint the pre-pubescent years of late childhood are more closely related to adolescence than to childhood, as it is at this time that the body begins to undergo the developmental changes which bring about puberty upon which the characteristic physical and mental aspects of adolescence depend. Hence in discussing adolescence from a physical standpoint we must necessarily begin with the period of late childhood. Adolescence is not a sharply defined period with clear cut limitations, but emerges gradually from the period of childhood and then merges almost insensibly into fully developed manhood or womanhood. Although in the symposium we are discussing the subject from three angles or aspects, I feel it incumbent upon me as the first speaker to make it clear to you and to emphasize that during this period the body, the mind, and the physical and mental education are inseparably connected, just as physical condition, growth, and development are intimately involved with the mental processes and reactions. It is impossible to discuss any one phase without considering the others.

The important feature of the period of adolescence from the physical standpoint is the development of puberty by which the body of the child undergoes changes which enable it to fulfill the primary function of biological life—the carrying on of the race. Until the tenth or eleventh year of life there is relatively little difference between the bodies of the boy and the girl. They are strikingly alike in size, weight, and organic structure, and the curve of physical development and growth is practically the same from birth. At about the tenth year the girl begins to put on far more weight than the boy, although their height remains about the same until the thirteenth year. As he approaches his thirteenth year the boy begins to grow taller and the increased stature of the male which persists through life first becomes manifest. At the same time his gain in weight increases at a tremendous ratio and passes that of the girl.

Tall children as a rule put on their weight earlier in adolescence and children who are shorter than the average tend to put on their weight at a somewhat later period. Practically every organ and tissue of the body takes part in this increase in size and growth, but the most important parts affected are the skeleton, muscles, organs of reproduction, and the heart. What governs and brings about these changes is

a question that can only be answered in a general way. The internal secretions of the endocrine glands undoubtedly play an important part, but the part played by each gland and their seemingly complex inter-relationship, as well as what brings about their functioning at this time, is to a large extent a physiological mystery and most of our knowledge at the present time is based upon the study of dysfunction.

Taking up in detail some of the changes which take place it is interesting to note first of all the increase of basal metabolism during adolescence. Du Bois has found by careful calorimeter study that the basal metabolism of boys at puberty is some 25 per cent higher than the basal metabolism of the adult. When one adds to this the additional food requirements for growth and muscular activity of childhood at this period it is easy to account for the tremendous amount of food required by the growing boy. In studies made at one of the Eastern preparatory schools it was found that boys from 13 to 16 years old took approximately five thousand calories daily and apparently required this amount, a figure nearly half again as much as a farmer at his daily work requires.

The large bulk of the increase in size and weight is due to the growth of the skeleton and muscles. Just before and after puberty there is a decided increase in bone growth until at about 16 the skeleton makes over 23 per cent of the body. Until the twelfth year in girls and the fifteenth year in boys the growth in stature chiefly involves the lower limbs and after that time the gain in height is chiefly a body height gain. The most striking change in proportion occurs in the pelvis of the girl—the iliac arch broadens and the transverse diameter becomes greater than the antero-posterior diameter. As a result of this change in the pelvis, together with the muscle growth, the circumference of the body at the hips becomes from one and one half to two inches greater in the girl, and the female configuration becomes established.

In many ways the marked increase in muscular development which takes place during early adolescence is of paramount importance. At eight years of age the muscles form about 27 per cent of the body, at 15 years 32 per cent, at 16 years 44 per cent, and in the early adult stage about 45 per cent. Between the thirteenth and fourteenth year the muscles of the arm of the boy increase 100 per cent more than at any earlier period and this is exceeded by the growth of the muscles of the legs, thighs, and back.

At the risk of trespassing upon the field of one of the other papers, I wish to emphasize the muscular growth at this period, as few stop to consider the importance of muscular growth tonicity and reaction in our daily life and its significance and importance is not at all understood

by many parents and teachers. It is the muscles which carry out the impulses and directions which come from the brain. No matter how much we may will to do a thing or how intensely we may desire to control our actions, it is the muscular system which in the end result carries out our desires and which determines ultimately the course of action and reaction. As a result, our habits in large part depend upon our muscular system and our habits are determining factors in our character and morals. Body fatigue is dependent to a large extent upon the exhaustion of the muscular system and fatigue is one of the most important determining factors in the health and well being of the individual.

With the rapid muscular growth that takes place during adolescence muscular exercise and training are most important. The interest in physical play and sports which develops at this period is a normal expression of nature's demand in order that the body will develop to a normal maturity. The picture of the ungainly awkward adolescent child so familiar to all of us is the result of the failure of control and coordination to keep pace with the rapid muscular growth, combined with the tendency of the muscles to grow in length more rapidly than the bones. A definite program of athletic or physical play is as necessary and as integral a part of the educational life of the adolescent as the school program. With the rapid growth of the skeleton and muscles faulty posture from unequal use of muscles or from the maintenance of bad position in school is very apt to occur. At times this leads to fixed curvatures unless care and attention is given to proper forms of exercise and the avoidance of faulty posture in school and at home. Owing to the differences which take place at this period in the development of the reproductive organs, the same type of play and forms of exercise are not as a rule desirable or suited for the two sexes. The development in recent years of forms of outdoor sports and recreation for girls is to be encouraged, but in arranging such programs the difference in the anatomical development of the sexes must be kept in mind.

Changes either absolute or relative occur in almost every organ during adolescence. Thus the thyroid increases and in girls in particular the enlargement frequently becomes noticeable even to the untrained eye. This so-called physiological goitre usually disappears after menstruation has been established for a year or more. Whether it bears any relationship to the development of goitre in later life is unknown. With our newer knowledge of thyroid function we attribute the increase that takes place in the size of the gland as a response to nature's demand for an increased supply of iodine. Hence today, rather than ignore the physiological thyroid of adolescence, we regard it as an indication for the therapeutic administration of an iodine salt. On the

other hand, the thymus gland—so large at birth—becomes smaller during adolescence. The brain is of particular interest in that it ceases to gain in weight at the very beginning of adolescence, although finer structural changes continue to take place. The lungs show a rapid increase in vital capacity.

Of more interest and importance are the changes in the heart and vascular system. In response to the demand put upon it by the growth which takes place during adolescence the heart nearly doubles its size during the period. As a rule it develops hand in hand with the increase in general growth but at times one finds a rather slow cardiac increase and that the heart of the boy of sixteen or seventeen has only the functional capacity of the heart at eleven or twelve. Very frequently one sees minor irregularities in the rhythm which usually pass away and are unimportant. Children with these arrhythmias have occasionally been diagnosed as having a severe or chronic type of cardiac disease, when in reality the disturbance was purely functional or nervous in origin. At birth and during early childhood the blood vessels are relatively large and the heart small. As the heart increases in size the ratio changes rapidly and so from a ratio of 25 to 20 at birth a change takes place to 140 to 50 at early puberty and then rapidly to 290 to 60 at maturity. Recent blood pressure studies by Starks and Kern have shown that the pulse pressure rises uniformly until the pre-pubescent years, then, as a result of a rapid increase in systolic pressure and a slower increase in diastolic, the pulse pressure increases rapidly until the seventeenth or eighteenth year when it falls to its original level. They consider this an indication of a marked increase of work per unit weight of cardiac muscle during adolescence. There is a very practical side to the changes and increased demand thrown upon the heart during adolescence. While a certain amount of exercise is essential there is an always present danger of throwing more strain upon the heart than it can stand, leading to a temporary or even permanent weakness. As a general rule one can say that forms of sport or exercise (as rowing or middle distance racing) entailing a long continued strain upon the cardiac muscle are to be guarded against and avoided.

As stated above the most important event in the adolescent period is the development of the reproductive organs and the awakening of sex interest. Medically we are accustomed to divide the development of sex characteristics into two groups—primary and secondary—the first involving the true organs of reproduction and the second the accompanying changes, as the development of the mammary glands in the girl and the growth of beard and change of voice in the boy. Depending somewhat upon race, climate, environment, and so forth, we usually

note the first changes in the girl at 12 or 13 years of age, although without definite pathological significance they may develop earlier or be delayed by a number of months. To the casual observer the growth or filling out which is so noticeable at this time is marked by the decided increase in the circumference of the pelvic girdle. These visible changes are brought about not only by an increase of the external body tissues but by actual change or enlargement in the pelvic cavity and the change in bony structure which was mentioned above. Further they parallel marked enlargement of the organs of reproduction situated in the pelvic cavity which up until this time are rudimentary. As these organs enlarge the gradual development of the changes in the lining of the uterus takes place, which periodically recur and which prepare the womb to receive an impregnated ovum. This periodic preparation for reproduction which forms the menstrual cycle is the most important event which takes place in the development of the adolescent girl. Closely dependent upon it are many of her physical and mental reactions. For some reason or other nature has not seen fit to make the boy pass through a phase or cycle comparable to that of menstruation. Much more gradually and without physical disability or break he develops the reproductive function.

I do not consider it necessary in this type of paper to go further into a detailed account of the development of the sex organs or changes which take place. I wish to put all emphasis upon the fact that this period from a physical standpoint is the period of sex differentiation, and secondly, that there is marked and decided difference not only in the form but in the degree and effect of the development of the sexes—a fact which I think must be clearly kept in mind in developing our educational and health program for the late childhood and early adolescent years, as it is my impression that there is a tendency to ignore or gloss over certain fundamental biological facts.

In conclusion I wish to add a few words regarding sex education from the viewpoint of the physician. In my opinion it is a subject for the home and not for the school. While we know and must admit that by far the vast majority of children have received from their companions some knowledge of sex problems and sexual matters, it is interesting to note how little real impression it makes upon a child before the age of adolescence.

The essential thing for the adolescent girl is to be prepared for menstruation. Let her learn other things later on. There is nothing more dangerous than for menstruation to develop suddenly in a girl who has not been prepared for its appearance. Many a sensitive girl at this age has been so badly shocked and frightened by its unexpected

appearance that it has upset her for years. Secondly she should be taught that it is a physiological process and not a pathological one—that is, that she is not sick in the sense of having a disease. The term “sick” should never be used. Mind and matter are closely interrelated at this period. There is no question but that a large part of the chronic invalidism of women is largely a mental reaction which had its origin in adolescence arising from the girl being impressed at this time from a wrong viewpoint. She should be taught that a moderate amount of pain should be borne and disregarded. Under average conditions it is only necessary for the young girl at this time to slow up a little—not give up. Both from a physical and educational viewpoint her life must be eased, but unless conditions are definitely abnormal she should be kept at most of her daily routine. Another point is the change in temperament and disposition which not infrequently occurs in cycles corresponding to menstrual period before it actually begins. A change in appetite and minor hysterical manifestations, attacks of faintness and flushing are frequently seen. Owing to the different type of outdoor life which the girl of today leads the anemia symptoms of puberty and adolescence, so common in past years, are now rarely seen.

With boys we have no corresponding phenomena and hence in some ways our problem is easier. The only satisfactory form of sex education I have ever encountered for the boy is a fine normal natural relationship with his father or some older man whom he likes, respects, and trusts, with whom he can discuss his problems. The chief problem the physician encounters with boys is the mental reaction of masturbation rather than the physical. Social hygiene instruction should come after puberty, not before.

The gist of sex education is a happy normal relationship between parents and children which must have its beginnings long before puberty. The most important thing for parents to understand in regard to adolescence is that their child is undergoing far-reaching fundamental physical changes and that there is a physical basis back of all the peculiar and usually irritating changes in temperament, disposition, and attitude toward the family and life which are so prone to develop at this time. For teachers and educators it is necessary that they have a full realization of the tremendous growth and development which is taking place at this time and that educational problems must be correlated with the physical problems.

PROBLEMS OF LATE CHILDHOOD AND ADOLESCENCE— MENTAL ASPECTS

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The tendency to divide up man's life from birth to death into periods is as old as man's curiosity about himself and that is very old indeed. The prenatal phase has come under the scope of inquiry while that longish period after death still remains somewhat speculative. With these exceptions the remainder of man's life is open to observation and study and to some extent to experiment. Perhaps no better example of the periodic point of view exists than the poet's seven ages and perhaps no one has better characterized the essential differences between them. At the present time, however, interest is centered on a more tangible and practical attitude towards this subject and something is needed more realistic than the poet's fancy and imagination. There is a desire to subject not only man's life as a biological phenomenon to whatever scientific scrutiny is possible, but also to examine each phase or period with some sort of objective analysis. Man as a social and man as a biological unit are no longer parallel lines in a scheme of inquiry, but are one essential problem, highly complex, often inchoate, seemingly undecipherable, but nevertheless the most common and significant problem that exists.

To that part of man's life which is roughly bounded by the beginning and completion of maturity much interest has always attached because it is in the unfolding period that processes are less complex and hidden than in the finished state. As man develops into his more rigid and unchangeable final form he goes through a sort of experimental and adjusting period during which the elements of his future personality can be observed or rather conceivably might be observed if methods, opportunities, and knowledge were sufficiently formulated. Roughly speaking this is the period commonly called adolescence. The physical characteristics and their relation to the maturing sexual and other glands are not within the scope of this paper. It should be kept in mind, however, that it is extremely difficult to consider the mental and physical as separate questions. Of some interest is the fact that there seems to be no essential parallelism between adolescence as a physical phenomenon; that is, of growth, and the adolescent personality, state of mind, content of consciousness, behavior reactions, or what you will. Adolescence from the point of view of this paper is then that period in a man's life cycle which represents impulses towards conscious social adjustments and the overcoming and final molding into sets of habitual

activities the conflicts which naturally arise. The dynamics behind these impulses are intimately associated with the rhythm of growth of which glandular activities, and especially those of reproduction, are of the greatest importance. I have then, therefore, roughly defined what I mean by adolescence and I hope you will share the idea with me and sympathize with its rather obscure delimitations.

The point of view of the inquirer is important because it hints at his material and suggests what might be called his scientific right to speak out loudly or not at all. Some of my psychological friends and colleagues have suggested that a neurologist is off stage in the adolescent drama and even his place high up in the gallery as a modest observer of life is seriously questioned. I cannot help remarking, however, that a neurologist has, by virtue of his specific interest in the problems of personality and behavior, an opportunity of unusual richness in the presence in his daily life of adolescent individuals who come to him or are brought to him for study, advice, and care. He must be a dull and highly unimaginative individual who does not gain a bit of insight into these ever perplexing human situations. Therefore my point of view is that of a physician concerned with the total problem of the nervous system, which implies among other things the consideration of man's conduct in relation to his environment. Adolescence as a theoretical phase in the development of the individual is one thing and the study of the adolescent individual is another. The conception of an adolescent of and by himself is a third. These are the sources of what information we have and it is essential to make use of all of them to enable us to get any notion whatsoever of this period. No consideration of adolescence is promising unless some idea in regard to the psychological mechanism in that period of life is obtained. If that is once clearly appreciated or, such of it as can be, then the mental aspects clustering about, in and out, of this epoch can be approached even in so brief a summary as this is bound to be. This outline may serve the purpose of opening a door for discussion and suggestions with an undogmatic and not too obscure objective.

It is possible, I believe, to characterize in a few words the predominating psychological characteristics of certain well defined periods in the life cycle of a pre-adolescent child as a kind of preparation for the sudden inrush of impressions, ideas, and associations which usher in the period under discussion. The infant phase is largely pure instinct in which stimuli, excitation, and response are associated with nutritional necessities—food, warmth, quiet, sleep, and the vague beginnings of purposeful movements looking to change of place and position. These with coordinating muscle effort towards independent mobility are per-

haps the most significant items. The organization of these instinctive impulses into some pattern of habitual action influenced by environmental experience of a restricted and protected kind are noteworthy features of the second period which for purposes of description may be called early childhood. It is here perhaps that elements of our common social inheritance are laid down, chiefly as a result of commands, orders, and disciplinary maneuvers of various kinds. The source of authority and the origin of control are parental or some representative of that source, nurse, elder brother or sister. The taboos, customs, conventions, fears, superstitions, and all the rest of our social plunder are handed out and accepted, some painfully it should be admitted, some without question and all without debate. The chief social mechanism is the slowly developing faculty of speech, by which the child is brought into relation with his environment other than by physical contact. The social inhibitions are no longer put into force by physical means alone but by the use of words, phrases, commands, and what not. The child not only learns to talk but is also instructed as to what not to say or told often to say it in some other way. In this simple fashion the repressive faculty is given opportunity to develop and the devious uses of speech to hide meaning and distract attention are duly exercised. The social function of the developing personality is restricted largely to contact of a family sort where liberty of action is limited. In play and games and such amusements as are possible at this tender age are given play to that inner function of consciousness which is called imagination.

With the period of school the child enters often acutely into a much broader social life and becomes in a sense a more independent personal unit; at least his contacts are broadened to include individuals entirely out of touch with his own particular home circle. He is aware of numbers of other children and meets perhaps his first important test at social adjustment. His early training in inhibitions or repression is about all the mechanism he possesses to meet this new demand. He steps into a new world, which he finds fully organized with its own authorities and its own laws, taboos, and orders, and discovers a rigidity of conduct often surprisingly similar to that of his own home, but curiously less individual. He becomes a part of a machine which functions with a regrettable degree of smoothness. Into this conventionalized life the school child fits smoothly and the cog wheels of his life move on with scarcely a noticeable jar. I need scarcely remind you that I am speaking of the average child in an average grade school. The exceptional child and the exceptional school are at the present time so insignificant a percentage that they need scarcely be considered.

In this brief sketch a few significant psychological mechanisms stand

out which are of much interest in the attempt to analyze the adolescent stage toward which this child of ours is rapidly approaching. Instinctive and primitive tendencies, curiosity, adaptation, inhibitions, taboos, conventional conduct, repression, and the escape through substitute types of action, imagination phantasy, the heroic impulses, and the personification of this impulse in actual and living persons—of the emotions, fear, dread, and the apprehensive trends are possibly the most significant. Naturally a real child is not made up of these qualities in any such fashion as has been here outlined. No one unacquainted with a child would ever be able to visualize one if he put together all these things and a thousand others too. Yet if we try to set down some of the qualities of a child's make up, as we might describe his physical appearance, his clothes, his expression, some of the things that have been mentioned would have to be noted.

Somewhat suddenly in many instances and gradually in others there takes place a remarkable change. First physically and then mentally. The resulting change drives the child forward irresistibly to the necessity of a new orientation of himself in relation to his environment. The dynamics of this change lie in the rhythm of growth and particularly in the awakening of the internal secretory glands and especially those that are concerned in reproduction. The physical result is seen in the development of primary and secondary sexual characteristics and the physical changes associated with them. The adolescent child, physically I mean, needs no outlining here—what does perhaps deserve comment is the relatively incomplete preparation mentally for the larger physical demands. It is this lack of proportional growth which forms so distinct an element in proper adjustment. That nothing dramatic or disturbing happens in the great majority of cases is due to the inherent elasticity in the human organism as a whole and to the fact of our biological inheritance which sees to it that the human species cannot become extinct in the very initiation of its reproductive stage. A study of this "nothing that happens" is the key in my opinion to the total problem of adolescence, and it is here too that the mental problems of the adolescent are really focused.

If it has been possible to suggest some of the complexity in the mental organization of an adolescent's mind, derived from the interplay of elements making up consciousness, then it will not be difficult to appreciate the increase in the burden of mental assimilation which now takes place. With the sudden or gradual sensitization to external sense impressions caused by the physiological hyperactivity of the total adolescent organism, a change in the mental make up of the individual becomes apparent. Vague ideas associated with past experiences be-

come fixed and grouped about new types of functions related to anatomical and physiologically insistent organs. This need not in any sense be limited to the sexual glands, which I am inclined to believe have been rather over-emphasized in the description of the adolescent state. The complete organism, so to say, asserts itself and becomes a real and personal entity in consciousness. The adolescent in a sense begins to feel himself and to establish a precise sense of personal awareness. The oft repeated self-consciousness of the maturing boy or girl has in this regard a very positive material framework, preceding the realization and formation of the existence of one's self as a definite thing and as a distinct and recognizable figure. The extraordinary interest which this phenomenon creates and the conviction that there is ready at hand a mechanism for its study furnishes one of the most outstanding characteristics of the adolescent mind, that is its quality of introspection. Contemplation of self and the fascination of becoming acquainted with it are activities which to the adolescent far surpass in interest the world of reality in which for the first time he consciously feels himself. Past impressions, ideas, experiences, vague formulations of all sorts of notions, fears, doubts, phantasies, and dreams have to be organized about and within this new figure. At the same time that activities of this kind are going on, the outside world in its new orientation is pouring in new sense experiences, new activities and new contacts. I use the word new in this place because it is the sharpened sense of realization that furnishes the novelty not the fact that they have not occurred before. Previously known material must be adjusted to recently acquired experiences and some sort of compromise has to be worked out so that the adolescent does not, so to speak, "blow up." When no such compromise is possible then there happens that most regrettable adolescent shipwreck called by the ugly name "*dementia præcox*."

I suppose it is possible to set down in some sort of orderly fashion, even in so brief a sketch as this, the outstanding adolescent features with such qualifications as may seem essential. Some of them are the beginnings and elaborations of personality of a conscious sort, the awareness and sharpening of the conception of a separate unit in a social group, distinct, and mutually antagonistic perhaps, the sense, doubtless very slight in most instances, of some sort of a struggle for survival. This may be merely an echo derived from the infantile struggle to exist now made realistic by the understood presence of the one among the many. The development of the primitive beginnings of introspection with its effect in the formation of the inner life and the almost automatic grouping there of what seems most precious and worth while. The richness and variety of this inner world differs enormously, but some trace of it

is always found in the most dull and least imaginative adolescent. There is too a marked trend towards concrete conceptions. The childish idea of good was to be good, of truth was not to tell a lie, of religion was to go to Sunday School, and so forth, now a vague reaching out for the concept itself becomes manifest. There is a transfer of interest from performance to motive, purpose, and meaning. The question mark is more important than the period, and the question itself more evident than acceptance. The sharply accented awareness of a world outside one's self, a rather awkward, stupid, and misunderstanding world, turns the adolescent mind away from reality into that more splendid and fascinating place, his own mind, where he walks heroic, unafraid, and master. The mystery, the urge, and the fear of sex create a complex state, the meanings of which are perhaps beginning to be somewhat apparent, become now a tangible thing associated with the whole phenomenon of reproduction developing out of infantile ideas and crude, defective, primitive information. There is also a reawakening of childish fears in the presence of a world more definitely present but less understood. The groping for some authoritative figure, less dull and more understanding than parents, teachers, or companions, suggests the reason for the adolescent's sudden interest in religion and the awakening of what might be called with a good deal of reservation the mystic attitude.

Out of the sudden awakening of the internal mental life, largely through the influence of the sexual development and differentiation and with the more frequent use of introspection, a definitely direct impulse to consciousness of self and personality comes about. The richness of this period as far as mental possessions is concerned differs widely as do also differ the amount and quality of the introspective tendencies. Whatever this difference may be there results one of the outstanding features of all adolescent type, that is the conduct manifested, as shyness, awkwardness, reserve, moodiness, embarrassment, and so forth. All these seeking some kind of outward expression find the muscular mechanism inadequate, the rapid adolescent growth, increase in weight, heart capacity, and so forth, touched upon by Doctor Veeder, are not as yet properly trained, measured, and adapted to the swiftly increasing demands that spring up insistently in the mind of the adolescent child. Therefore, from the outside are seen the awkward movements, the restlessness, and the clumsiness that are characteristic of this period. The child is trying out, so to speak, a muscular machinery that gets away from the steering wheel and the system of regulation which formerly were adequate for a much less powerful apparatus. There is then the awakening of self-consciousness, the capacity for introspection, the in-

tense realization of a vast territory of unexplored mental experiences. There comes, too, a settled conviction that there is ready at hand a means of appreciating all this through the mind itself. An adolescent child soon learns not only that he has something in his mind but that these things are his and that he is the only one that can see into them. The tendency for the adolescent to withdraw into himself, which so often alarms the parent, is the natural and normal trying out of an intensely interesting mental mechanism. There is, too, an additional instrument for expression which the so-called imaginative child becomes increasingly fond of, that is, day dreaming. This is the extension of mental experience through fancy, uninfluenced by space or time, and no doubt joined to the early and more clumsy efforts at this pastime, referred to earlier in this paper.

Over and against all this and surrounding it, enclosing the adolescent like a shell of metal, so resistant, hard, and inelastic it seems, is the world of reality,—of people, authority, inflexible social and traditional customs, taboos, commands, duties, tasks, and responsibilities. The adolescent might well say with Marchbank in *Candida*, "I wish I could find a country where the facts were not brutal and the dreams not unreal." Out of this situation there develops that first serious revolt against what seems wholly unnecessary. This may often be so slight as to be imperceptible and then again it develops with a flame-like intensity that creates the most annoying social results. This is the basis of that conflict tendency seen in every mind but especially characteristic of the adolescent because it is so free, fresh, and innocent. No understanding of the adolescent mind can be obtained unless the adolescent conflict is fully appreciated. It arises from the lack of adaptation to the world outside which the early inrush of mental expansion brings about. I should say then the adolescent mind is characterized by the physical expansion, by the influence exercised through the awakening functions of the sexual glands, by the development of introspection, and consciousness of self, by the ownership of mental possessions, by the contrast of this treasure and the external world, the conflict processes, and the repressive measures so necessary for any sort of social adaptation. To this must be added the conduct and behavior reactions which both Dr. Veeder and I have called to your attention. Please keep in mind that I have attempted to picture the more outstanding traits of the mind of one anywhere from eleven to twenty-odd years of age. Out of all this and much more that I have omitted and more which I am not wise enough to know, arises that distinctive characteristic of the adolescent which separates him once for all from his previous state—the adolescent conflict. I have tried to lay down some of the sources of

this conflict; that is the key to the understanding of this period, I cannot doubt. The essential release is through some measure of adaptation. Here is initiated a maneuver which in some form or other will be present for the remainder of his life time. It might be said that the adolescent period is simply the preparatory shifting ground for future adjustment and adaptative maneuvers for overcoming or compromising with environmental conflicts.

The problems presented by the adolescent are three-fold; first there is the adolescent himself, then there is his immediate social group, and lastly the world outside. Further to simplify the setting it is possible to distribute it between the adolescent and the world outside of himself. I believe no adequate notion can be obtained unless it is appreciated that between them there is a mutually felt kind of antagonism. This antagonism is implied in the descriptive phrase adolescent conflict previously pointed out. Some of the sources of this conflict have been mentioned enough, I am assuming, to warrant its acceptance, at least from the point of view of this paper.

In mere outline the difficulties implied in this age may now be touched upon. I suppose social adaptation would come first. This would be a very different, varied, and individual treatment. Here we meet with physiological differences of a most vital and important kind. How much of the mental characteristics I have just described owes its origin to impulses of a sexual nature, it is difficult to say. How much such impulses are sublimated, as we say, into channels, which apparently are far removed from such origins, is a question just now arousing the interest of all those seriously concerned with the adolescent problem educationally and religiously. These two must be considered separately, because they represent a demand, a need, and means of adjustment. The presence of conflict and the uncertainty dependent upon that psychological state reaches out for something that removes the sense of impotency and replaces it by a feeling of security reaching beyond the individual and beyond his social contacts. The state of ready acceptance thus produced renders the adolescent readily susceptible to the influence of organized religious demands. Education, which implies here more than school, creates a way out chiefly by the organized power of mental discipline and by the cultivation of discrimination and choice. The home is the next consideration and perhaps for the adolescent the most vital source of guidance. That it should be, but so often is not, is due to the lack of insight and intelligence on the part of parents and brothers, and sisters, who see in the adolescents of their household merely a passing and puzzling phase of a period which they know will soon pass, or, as it is commonly put, be outgrown. Frankness, knowledge, and

courage on the part of the parents are needed. The world of reality must be made a part of the adolescent's mind and he must see in that something of the interest and adventure he finds in his own mental life. There is no formula and no panacea. The adolescent problem ceases to be one, I suppose, if we adults, we fathers and mothers, rid ourselves of the illusions, false standards, conventional and stereotyped striving after things and see the realities of life with something of the poetry and vision which flames up in the minds of our adolescent children.

EDUCATIONAL PHASES OF EARLY ADOLESCENCE

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This paper is an attempt to suggest an answer to these questions: What is the significance for education of the facts of early adolescence so ably presented by Dr. Veeder and Dr. Schwab? What changes in educational practice do these facts of early adolescence demand? What must I do as the head of a school responsible for its administration and conduct?

I must meet the challenge, for challenge it is. I must somehow adapt my school to the needs of boys and girls of this age. They are neither children on the one hand, nor youths on the other. A school life adapted to children is not suited to them. Neither is the school life which is suitable for youth, for young men and women, best for our boys and girls who are passing through this stage of transition.

Almost all children below the seventh grade, those who are in the first six years of their school life are pre-pubescent. Almost all who are in the tenth grade or beyond are post-pubescent. Therefore, grades seven, eight and nine include almost all boys and girls who are passing through this period of readjustment. The challenge to me as an educator is to provide such schooling as will fully meet their needs and such as will hold them in school and send them—all of them, if possible—on into the senior high school and many to college. It must be evident to them and to their parents that they are getting what they need and that they will profit by continuing their education. Such a school may be known as an intermediate school, or junior high school, or transitional school or by any other name you wish to give it.

This school should provide for a proper co-ordination between the elementary school which is for the child, and the senior high school which is for the youth. At present, school organization is faulty in that it permits a sudden and radical change from the elementary school to the high school. The facts of early adolescence demand a different arrangement. The transition from the school of childhood to the school of youth must be gradual just as is the transition from childhood to youth. Instead of the sudden change from a study content which is simple and easily understood to content and text books much more difficult, there must be a gradual increase in the complexity and abstractness of the problems with which our boys and girls have to deal.

There must also be a more gradual change in the manner of teaching. In the elementary school the child has been accustomed to doing the greater part of his study with the one teacher who has been responsible for almost all of his work. There is a sudden plunge into a large

high school where he has many different teachers, where he goes from one class room to another, where he is left largely to his own devices as to how he should study. He is lost and confused, and no wonder. The needs of children of ages approximately 12 to 15 demand that we teach them how to study; that we work with them intimately, giving them sufficient, but not too much guidance in methods of study in order that each one may learn how to do his own work in each field of study in the way best adapted to him. This should lead step by step from large dependence upon the teacher in the beginning to greater and greater independence until the student reaches the senior high school, when satisfactory and efficient habits of study should have become established.

As an educator I must recognize that these children differ remarkably in abilities, in tendencies, in physical, mental and social maturity, in emotional stability, in home life and social background. I must recognize these differences and make provision for them. As far as possible, I must group them in such a way as to make it possible for each one to travel at his own pace, that he shall be expected to do as much as he is able and no more—to use a homely illustration from the farm, that he shall be expected to keep his traces tight but not to draw a load which is too heavy. This is just as important for the capable child as for the slow pupil. There is danger that the child of pronounced abilities shall form habits of carelessness and loafing because the work does not provide sufficient challenge and stimulus for his abilities. We have no more important obligation than to see to it that our capable children are developed to the extent of their capacities, for from them a large part of the leadership which America needs in all walks of life must come.

That division of my school for the children of early adolescence must provide opportunity for exploration. It must enable them to explore their own capacities and tendencies and inclinations. For the great mass of boys and girls in America these years are now the last in school. The choice of occupation is forced upon them early. They must be making decisions. It is our obligation to them to provide a school situation in which they may test themselves, in which they may have some experience in the great fields of human endeavor. The curriculum, in my judgment, should not be vocational but pre-vocational. It should be such as to open their eyes to the work of the world; to see what they may do and to be guided as far as it lies within the power of teachers and parents, into wise choices. For those who are not leaving school, who will go forward to completion of high school and possibly of college, the immediate necessity of choice does not exist, but they, too, need to begin to think about these matters and to see themselves more clearly in relation to the work of the world.

I have no more important obligation as a teacher than that of fixing a high quality to the life lived by these pupils in school. That intangible thing which can be neither seen nor heard, but which everyone feels, sometimes called school spirit or school atmosphere, is of the utmost importance. In their rapidly expanding lives they are sensitive to this powerful influence. I must remember that they are living, not simply preparing to live; that the surest preparation for deep, full, rich life in maturity is the same sort of life through childhood and adolescence. Such a school life must be characterized by variety. Pupils at this age should not be expected to hold their attention for any great length of time upon any one thing. There should be variety in studies, in subject matter, in school activities. The day should be full of interesting, profitable activities of mind and body. Moreover, for them the school day must be free from strain. The nervous tension which sometimes characterizes boys and girls of this age as a result of their school work is harmful, and while the school day must be a busy one it must be free from those things which make serious drains upon their nervous resources.

There is no time in the life of a pupil, unless it be at the time of his entrance to school, when he is in such need of teachers of understanding hearts. It is my obligation to provide, especially for the pupil in early adolescence, teachers of sympathy, patience, kindness, and insight. They must not be the sort of teachers described by a certain superintendent who wrote:

Tell my teachers when I am dead,
That they need shed no tears,
For I shall then be no more dead
Than they have been for years.

They must be thoroughly alive, vigorous, and altogether human.

The intellectual life of pupils at this age should be vigorous, full and free. We should not expect extremely high intellectual achievement such as we have a right to expect in the later high school and college years. There should be no great concern at this time about school marks or grades. The intellect should be none the less active, however. It is a time of mental out-reach. Children come to us with intellectual curiosity, eagerness, zest. It is a tragedy when we send them away with that crushed out of them. And it seems to me that there is particular danger at this time. It is easily possible to dampen the ardor and kill the zest of a thirteen year old boy in school. On the other hand, it is equally within our power to meet the out-reach of his mind with new material inherently interesting and profitable so that his intellectual curiosity is at once satisfied and stimulated to further activity.

It is a time primarily, I think, for the establishing of permanent interests. It is possible now to arouse enthusiasm for school work in many fields if it is properly presented. Through wise guidance, the pupil may now be set upon the road which leads to intelligent, discriminating, appreciative reading of good literature so that it will become to him, throughout his life, a source of gratification and satisfaction, or he may, by unwise teaching, be turned away from great books, one of the great springs of human happiness thus being dammed to him forever. He should, at this time, have many doors of the house of life opened to him and he should catch a glimpse of the riches in those rooms so that in later life, when school is behind him, he shall revisit those rooms filled with the treasures of the ages and find in them a source of enlarging satisfaction and life enrichment.

Further, he must not be allowed at this time to fail. Of course, it is good for a boy to learn that when he does not do what is within his power he has failed. What I would emphasize is the disaster of repeated and continued failure which is the result of expecting pupils to do more than they are able to do. Some schools attempt to maintain a high standard by making it impossible for many pupils to succeed in the tasks assigned. I think that is unfair, unjust, and extremely harmful to the pupil. Repeated failure leads almost inevitably to loss of self-confidence, to the break-down of self-respect. We can do nothing worse for a child at this age than to cause him to believe that he is a failure. The school for which I am responsible must provide for him profitable work which he can do and do reasonably well. Every pupil has a just right to make that demand of his school.

Social life in the transitional school must be abundant. It is a time of social grouping. The gang and the club make a strong appeal. Early adolescent interests lead to the formation of aeroplane, wireless, literary, dramatic, French, glee and mandolin clubs, to orchestra, choir, wild-flower clubs, astronomy clubs, camera clubs and various forms of athletic associations. This is the time for scouting. It makes its strongest appeal to the early adolescent. Later adolescence outgrows it. For those whom we are discussing, it is tremendously significant, and, in my judgment, scouting is one of the most important educational developments of recent times.

All of these things which I have mentioned have to do either directly or indirectly with the physical, mental and moral health of pupils of early adolescence. I wish now to say a few things as emphatically as I know how concerning my obligation as an educator for the physical welfare of the members of my school who are in their early adolescence. Every hour of the day must contribute to their physical welfare. There

must be nothing in the entire day which is a hindrance to their fullest physical development. In building the school of which I have charge my first consideration was the physical welfare of the boys and girls.

Our greatest fault in modern school construction is our failure to provide sufficient space for play. I am convinced that boards of education and school patrons everywhere must realize that a great deal more space for play is absolutely necessary. It seems to me the utmost folly to erect a building for one thousand, two thousand, or even three thousand pupils with only one acre, or two at most, for their outdoor exercise. For a school of two thousand pupils there ought to be, at the very least, twenty acres and it ought to be immediately adjacent to the school building. We must take this matter more seriously. If we are in earnest about it, we shall demand that every child in school shall have sufficient time every day for abundant exercise and that he shall have sufficient space for it. We hear much these days about reduction of taxes. We have a right to expect that, but let me say that the very last place in which we should attempt to cut down costs is where it affects the welfare of our boys and girls. And let me say further, that the American public must come to realize that the adequate education of their youth will cost not less, but more, and that for every dollar now spent we shall spend two and even more, when we fully realize the importance and the difficulty and the far-reaching consequences of education.

To more adequately meet the needs of the period under discussion, we must have a longer school day. There must be time in which to do the things we are attempting to perform. In our school near Saint Louis, the pupils are present from 9 to 5 o'clock. Their long school day must not only be free from strain, but it must be so divided and arranged as to contribute most adequately to the profitable use of those hours. In the middle of the morning we have an open period when the pupils are free to engage in their various clubs and group activities. At no time in the day do we have more than two class periods in succession. We take a full hour for luncheon and subsequent relaxation; we sit down at tables and eat a good square meal, thoughtfully planned and well prepared. We eat it leisurely and we try not just to eat but to dine. We have a half hour following the luncheon for relaxation or recreation and later a full hour and a half for wisely directed physical education not for the team, but for every pupil. Then a return to class rooms for supervised and directed study, laboratory and shop, home economics and the fine arts, and preparation for the next day.

It is my obligation as a school administrator to select teachers of physical education with the utmost care. They hold places in the school

in importance second to none. I demand of them the training, the study, the thoughtfulness, the skill, the intelligence that I demand of any other teacher in the institution. They cannot be primarily teachers of Latin or mathematics and incidentally coaches. Their first and only business is physical education. We provide for their work, time, space and equipment. We demand results and secure them.

There is one field, however, in which much of our effort seems to be wasted. We are still unable to prevent common colds. I am ready to do great honor to the physician or physical educator who will teach me how these may be prevented. They seem insignificant, but they are not. The loss of time due to absence caused by colds, the weakened condition resulting from colds which makes it possible for serious diseases to successfully attack a child and the consequent waste to both pupil and teacher are beyond computation. Colds seem to defy us and we seem to be able to do little to avoid them in spite of the utmost care in ventilation, clothing, food, exercises, baths, contacts and everything else. Here especially cooperation on the part of parents is a great need. We discovered last year that 65 per cent of all colds in our school were contracted at home over the week-end. Our next step in hygiene is a systematic, cooperative, definite effort to reduce and, we hope in time, to eliminate the common but often disastrous cold.

Someone has said of boys and girls of these years that "they are most unlovely, but most in need of love." Surely, those of us who are responsible for the administration of education in America must have such deep and abiding affection for these who are ceasing to be children and are beginning to become young men or women, that we shall see to it that they have the benefit of every sound contribution from the fields of physical, psychological and social science.

DISCUSSION

Charles W. Bradley, Head Master of Kansas City Day School: The physical program in the school has come to be a very, very important matter. There are some who feel that it has even become too important, and we encounter a certain amount of criticism on that score. Personally, I feel that the danger is that it shall not be considered important enough, and that we are not at all likely to do much harm in the way of over-emphasis.

The purpose of the physical program is not always fully understood by those who criticize, or even by those who uphold it. To many it conveys primarily the idea of recreation and amusement, or at best suggests a régime of physical exercises purely for the building up of bodily health. It serves all these purposes, of course, and it serves them well. But there is something more that is served by the physical program. In a recent article, "Too Young for Golf," by Walter Camp, he discusses the influence of athletic games for boys. The effect of the

sort of exercise a boy takes is more than a purely physical effect. There is a question of mental health as well as of physical health, of social health, of his relation to his fellows and to the community.

I have noticed for several years in school a quite distinct difference, between the boy whose only interest was in such games as golf, in certain parts of track work, or even in individual competition between himself and one other, in his own personal skill that is, and that other boy who played the team game—football, baseball, basketball—who was on the relay team perhaps rather than being a sprinter; a distinct difference. One type of athletic exercises helps to make the citizen, the man who does team work; and that is something of which we feel the need in all relations of life; we want the man who works with others,—in business, in politics, in every activity of life. I am sure that these team games have that to their credit, that, in addition to building up physical health and strength they have developed the men who work together with their fellows.

Speaking of football, I suppose that many people—perhaps mothers, especially—overestimate the dangers. Doctor Guthrie, formerly of Johns Hopkins, and for the past two years director of health of the Lawrenceville School, New Jersey, stated that he found a much larger number of accidents occurring during the baseball season than in football. But Doctor Guthrie's statistics covered two years in a school where every boy takes part in athletics in some form or other, and almost every boy plays football and baseball more or less. The statistics therefore did not simply apply to a team.

Referring again to Doctor Guthrie, because I know a good deal of his work, I might cite a little incident which illustrates a phase of the influence of the athletic program. A boy came to his school, about twelve years old, who was the typical fat boy, good natured, self-indulgent, not particularly interested in anything active, not at all interested in physical exercise, but much given to the pleasures of the table and very keenly interested in the press room. He was carefully examined. Doctor Guthrie began to make a friend of him, to advise him, and talk to him about questions of eating, of his weight, of his relation to athletics and to his fellows; and before any of us who were watching quite realized what was happening, the boy ceased to be the "fat boy." He trained down, was able to put on a much shorter belt, and began to play baseball, and the following fall football, and in less than a year, in place of a fat boy only mildly interested in his classes or anything else, we had a boy who was one of the younger athletes of the school, and the quality of his class work, his relationships with his fellows, and his own enjoyment in living was completely changed.

That is an illustration of one of the things a physical program may bring about.

Reference was made here to a classroom teacher who is incidentally a football coach. I do not think any disparagement was intended of the classroom teacher who teaches football. In our school every man is engaged in something of that kind, without taking the place of the physical director in any way. The boy studies his Latin with more interest when he finds his teacher can tell him something about football that is worth while learning in spite of all he is getting from the physical director.

To leave now for a moment the athletic side of the question, I find that in teaching these boys the great problem that comes to me as an administrator as well as a teacher is that of keeping patience with the seeming instability that we find at this age. The boy who today is very interested, very studious, very energetic, individually and in class, tomorrow will appear to know nothing and care less. It

is simply due to the physical change. I am not a physician, and I am not attempting to analyze this fact. The doctors who have spoken this morning have stated the case adequately and most of you know more about it than I do in technical terms, but I do know in practice that these boys of early adolescent age demand from us unlimited patience and firmness. The great danger, mentioned by Professor Aiken, is of coddling—coddling at home, and coddling at school. I speak chiefly about boys, because I am more accustomed to them; but I remember when I did teach girls I did not find such a very great difference in fundamentals. In both cases there is a real necessity for patience and firmness. The teacher, the father, the mother, who gets excited, who, as the boys say, “goes up in the air,” fails with them entirely. The young teacher, and the young parent, cannot understand how it is that Johnny, who was so bright yesterday, seems today so dull. I remember a boy who did exceptional work day after day and then suddenly, at what would seem a critical moment he went all to pieces, seemed to lose all he had gained. Then a day or two later one would find it all there still. He was often enough away ahead of the teacher of the class. His writing suffered in technic and spelling because his mind was more active than his brain. The point then at issue was the necessity of patience, steadiness and firmness.

Boys and girls at the age we are considering are leaving the period of childhood, with an interest in all sorts of things that they are touching here and there rather than digging into, while we are attempting to interest them in particular subjects. We must help them to investigate the possibilities in the world, in the field of learning and of activity, and at the same time we must find a way to get them to do some thorough work in some specific direction. Perhaps Professor Aiken may feel that contradicts one of his statements. I do not really think it does. I think something definite in some field has to be accomplished in this period as a step beyond the more general elementary direction.

So the problems to me seem to be the demands for steadiness, patience, and firmness in guiding these boys and girls, at a moment when they are unstable in their emotions, to take stock of their own possibilities, in helping them to make sure that they have taken this stock of themselves, and then in making sure that our program in the school, in the home, and in all other parts of the educational plan, shall include the physical both for health and for their relationship to their fellows, that what they learn may be for life's accomplishment and the spiritual or moral development which takes in the whole field.

Henry S. Curtis, Ph.D., Jefferson City, Missouri: We are coming to the realization that this period of pre-adolescence is the period of socialization of the individual. The child is passing out of the individualistic stage to the time when he wants to be with his fellows, wants to be in the team in all his relations; it is the time when boys and girls join the church, the time of the formation of gangs and things of that sort. Everything that we know about this period goes to indicate that it is the time for the team-making, the time which perhaps sees the foundation of the socialization element in life in the individual.

So we are putting in a program in the State of Missouri planning for team games for boys and girls and providing athletics for them. The new High School has a patch of five or six acres. Athletics so far have been organized by the student body for the purpose of winning games, and have usually not taken in more than five or six per cent of the students. The aim hitherto has been mainly to run faster, jump further, or do something else better than any other boy or than any

other school. The result of that idea has been a one-sided development, the development of a single set of muscles. We are trying to develop a different system, and the state is prepared to offer a series of medals to children who pass the standard tests. Five thousand medals are offered to us and will be given to the children who win in the contests.

We are going a step further. We are emphasizing health more than prowess in these tests and Missouri is also offering a state "Letter," the first time such a letter was ever offered. It is now offered to teachers' colleges in New York, based on a thousand points, one hundred points being in health, with a very rigid physical examination. To win the Letter, the person must have the eyes tested to see if glasses are needed; must have two-thirds hearing, skin in good condition, no enlarged tonsils or adenoids; must not stand with shoulders forward or have spinal curvature; must not be more than ten under or fifteen over weight. That is the first hundred points.

The second hundred points is in posture. The third requires a standing in scholarship of 80. He must get 100 in sportsmanship. If his standing is above 90 he may get 200 in this last. 100 points are for walking 100 miles in ten walks. Certain standards in athletics make for points, also leadership in student activities, or getting to be a second class boy or girl scout, excellence in gymnastics or dancing, or in different games, Soccer or American Football, basketball, tennis, and so forth.

At least 400 hundred points must be won from the first list, and 400 from athletics, in order to get the Letter.

I think that what is happening in education in the last two or three decades is that we are largely getting away from the idea of learning as the sole object to the idea of efficiency, or in the direction of efficiency. And we are trying to put into these tests the same idea. Every hundred points gained is an advantage to the individual.

They must have good health, a perfect body, good posture. They must have good sportsmanship, subscribed to by three teachers, good scholarship, a sense of service, and all-round athletic ability.

These are really the same conditions as those for the Rhodes Scholarships, and we believe that in future the distinguishing mark of a scholar will not be excellence in one line, but excellence in every line in which the school is interested. And every one of these points is an advantage both to the individual and to the school. In the case where a man gets his Letter simply in football, he may be a type that is not best for the student body to copy; he may get it from physical strength alone, and not from a combination of qualities making up the best type. But the man with a Letter given for the characteristics we have referred to will be a type of student whom the student body may well copy.

We are not only offering the Letter to the high schools, but to the colleges of the state. Sixty-six were won last spring, and there will be more than a thousand this year.

We have found wherever this has been offered that there has been great enthusiasm, and we have had good proof that it has been the means whereby the students themselves have been led to take a greatly increased interest in health. They themselves have asked for physical examination, and have evidently found a motive for working to rid themselves of physical defects to which little or no attention had heretofore been paid.

Mr. Wilson, Student Advisor of the Central High School, Kansas City, Missouri: One of the most obvious educational problems really is the question of accommodating the school system to both boys and girls at the same time, for the definite reason that by nature girls are conformists and boys are nonconformists. That can perhaps be illustrated from records of the senior classes. In a senior class of more than five hundred the scholastic record of one-fourth of the boys was not equal to an average of one-half of the girls. When choosing members for the national honor society, twenty-three girls in one high school had an average record over three years higher than the highest boy in another. Thirteen girls in another high school had an average record higher than any boy. And how does it happen? It is not that the boys are inferior in ability. We have quite definite proof to the contrary. But the teacher everywhere is faced with the problem of accommodating the course of study to boys at an age when they are not in the least appreciative of its importance or are not willing to apply themselves to it.

The second problem has to do with the development of faith in the school program. Unless we have faith, unless we can develop that faith, we can never develop any educational health. The adolescent throws out the challenge—Why study algebra, what is the use of it? Why study history, what good is it to us?—There is his challenge. When the adolescent throws out this challenge we must take it, and uphold our program in the light of an education whose aim is to make men and women. The response to ideals is especially dynamic in adolescence, so the adolescent will accept responsibility if he is once given a living faith in the program.

We have to remember how many and various are the claims on the adolescent boy's interest and on his energy. They are so many, they are so new, they are so bewildering that he hardly knows what is worthless and what is worth while. He is filled with a constant yearning for excitement. Half the secret of getting the adolescent to give his attention to preparing lessons is in finding for him some dominant related interest.

The fourth thing that gives rise to a serious problem educationally is a kind of educational anaemia. The student has to be taught not how to endure but how to enjoy the labor involved. Educational health consists in a joyous pride in the performance of a task, and this health can and must be taught. Once that health has been instilled, the student becomes conscious of educational ambitions. Often these ambitions are quite indefinite, often not permanent. On the other hand, there are times when a very slight influence may convert a wavering indecision into a definite choice. Very soon, we have to remember, these boys will be out in the world and we have to respond wherever we possibly can to their vocational yearnings by a wise guidance. I believe that educators will have to find time and means to give more and more personal attention to individual problems. The adolescent cannot be educated in the mass. His very nature demands individual guidance, and this guidance must somehow be afforded him, even though training may have to be given under highly socialized conditions.

These problems then come before us and must be met. They are the challenge of youth to which we must respond with faith, with a high belief in a possible foundation to be given them for a healthy, high-minded, intelligent citizenship.

ESSENTIALS OF COMMUNITY ORGANIZATION FOR CHILD HEALTH WORK

Presiding, BARRY C. SMITH, Director, The Commonwealth Fund, New York City

1. What are the Fundamentals in Community Protection of Child Health?

WALTER H. BROWN, M.D., Director Child Health Demonstration, Mansfield, Ohio

Discussion:

WILLIAM FRENCH, M.D.

2. Will Communities Pay for an Adequate Health Program?

BLEECKER MARQUETTE, Executive Secretary, Public Health Federation, Cincinnati, Ohio

Discussion:

H. S. MUSTARD, M.D.

3. Relation of the Press to Community Child Health Work.

R. H. HIXSON, Oklahoma Public Health Association, Oklahoma City, Oklahoma

Discussion:

SALLY LUCAS JEAN

4. Joint Responsibility of Public and Private Agencies and Obligations of Community in Observance of Child Health Program.

ANNIE S. VEECH, M.D., Chief, Division of Child Hygiene, State Board of Health, Louisville, Kentucky

America's Greatest Asset—Her Children.

Radio Talk: S. J. CRUMBINE, M.D., Director of Public Health Relations, American Child Health Association, New York City. Given under the auspices of the Health Conservation League as their weekly radio talk

ESSENTIALS OF COMMUNITY ORGANIZATION FOR CHILD HEALTH WORK

Presiding: **BARRY C. SMITH**, Director, The Commonwealth Fund, New York City

I have been about the vicinity of these meetings here in Kansas City for two days, and so far, though ample opportunity has been afforded, no one has made any attempt to give me any information as to how this particular meeting is to be run. I can only gather that there was a desire not to interfere with the inalienable right of a chairman to do as he pleases, and make all the mistakes he likes!

However, I should like to follow the scheme that has been largely adopted in the sessions, and call for the discussion immediately following the presentation of each paper. The papers will be twenty minutes' papers in each case. Then we will have ten minutes for discussion.

Having had the duty of presiding before now, I am well aware that a chairman is largely expected to be seen and not heard. However, I cannot resist the opportunity to inflict a few words upon you. Having received some of the papers in advance, I should have the advantage of knowing just what is going to be said, but being unfortunately of a naturally lazy disposition I have not read those papers. It is true that the ignorance of what they say may perhaps result in my being able to say anything I like.

The subject of the afternoon is "The Essentials of a Community Health Program." I have no doubt the speakers will present to you the picture of complete equipment, personnel, and plan, whereby such a program may be put into effect. What I would like to suggest is that among the essentials of a good community program are certain factors, certain things, that might be equally essential in other programs than those of health specifically.

Four or five of these essentials I want to mention briefly this afternoon.

One of the first essentials of a complete program is expressed in that much-abused word, "vision." Vision through both ends of the field-glass—vision that sees the need of the community in the future, that embraces the potentialities of a real program. We are all familiar with this idea. Some of us perhaps are inclined to call the man with vision visionary, and perhaps sometimes we are right—sometimes, perhaps he is visionary. But not always. There is another type of "vision." There is a vision that will make you look at your community with a careful detailed inspection so that you are penetrated with a realization of all its assets and all its liabilities, a realization that makes it

possible to determine whether in the particular conditions that exist such and such a program is one that will be effective or is not, whether it is adapted to the community in question, or is not. It is impossible, either in health or in anything else, to take a paper program, and apply it whole to any one community, and expect good results.

Then I think another essential for a community health program lies in still another much-abused word, the word "cooperation." Sherman Kingsley used to define that word by saying: "You cooperate and I will operate." Most of us, I am afraid, when we talk of cooperation, are really thinking that we will do the operating and the other fellow can do the cooperating. It seems to me that if there is any reality about it, it means getting together on a number of different lines. In the health program you must have cooperation of the physician in your community. The physicians must understand or must be made to understand what the implications of the program are, and be in sympathy with it. You must have cooperation of the Health Department with the private organizations instead of that rivalry and fear of interference which so often exists between the two. Also it is essential to have cooperation, a real cooperation between the different private agencies. We know how often that is lacking. How often it occurs that we see welfare agencies that have been organized to perform some particular service, well-conceived and well-equipped to do that service, after a while forgetting more and more that they were organized in the beginning as a means to an end, not as an end in themselves, as they at last have grown to seem. All of you remember that article in *The Atlantic* that declared that no single agency in the social field had ever decided that its usefulness was at an end, and that it was time for it to go out of business. Perhaps many of us believe we really have not finished our jobs, but even where that is true it is quite certain that it is necessary to vary the programs. Many things that have been done and are still being done can be dropped and in many cases should be dropped, and other things that changed conditions demand undertaken in their place. And if we are to cooperate in the true sense, it means that each one of us should be willing to subordinate ourselves to a certain extent in the interests of accomplishment.

Another thing. If there is anything in the world upon which the people of different churches ought to be able to combine, it is a health program, health work. Yet I have known, in several places, the various infant welfare activities, milk stations, and so forth, to be operated some by one religious body, others by another, so that the greatest possible friction was introduced into the work, with all the dreadful possibilities of a Presbyterian baby getting fed with milk from a Methodist or Catho-

lic cow! Real cooperation means willingness to subordinate organization and personal desires for the benefit of the whole community.

The last essential of the community program that I want to mention is a willingness to pay. Shortly after the Spanish-American War, I remember hearing a jingo speaker, one of those who was anxious to see the navy of the United States increased, commenting upon the niggardly appropriations for that purpose. He figured it out some way that the per capita for the increase amounted to about five cents. "What sort of a navy do you expect for a nickel apiece?" he demanded. I feel inclined to apply that to the health question. There are many places where they are not paying more than fifteen cents apiece for health. What kind of a health program can you expect for the price of a poor cigar, or the eighth part of a box of candy?

I have been told that fifty cents per capita is the most that any community can be expected to pay for health. I know of some that are spending from thirty to forty cents per capita for education, but I expect if we went back to 1824 and some progressive educator foretold that they would be spending any such sum on education, there would be held a commission on his sanity.

The organization with which I have the privilege of being associated is at the present time financing a Demonstration of Child Health, and we are so reckless that we are willing to spend, if necessary, as much as a dollar and a quarter per capita. If we succeed in accomplishing some of the things we hope in the way of proving that perhaps the expenditure of a major fraction of that amount is worth while in terms of community health, we shall be very well satisfied. It can be done.

The city of Bridgeport, Connecticut, is one city which is paying, I believe, a little over a dollar per capita for health work. The principal cause for their doing that is now going to address you in person, Dr. Walter H. Brown, formerly Health Officer of Bridgeport.

WHAT ARE THE FUNDAMENTALS IN COMMUNITY PROTECTION OF CHILD HEALTH

WALTER H. BROWN, M.D., Director, Child Health Demonstration, Mansfield, Ohio

A discussion of the fundamentals in the community protection of child health is peculiarly appropriate at this time. Many thoughtful health workers are frankly disturbed by certain untoward symptoms being manifested in various quarters.

The forced retrenchment of well established health agencies on account of lack of community support and the indifference of the public to the removal of capable public health officials for political reasons are signs of the times which must not be ignored. To be sure, such things have happened many times before and the public health movement has continued to progress. However, if our fundamentals are sound these unfortunate symptoms should occur with decreasing frequency and intensity. The writer is convinced that this is not the case. Lest I be classified as a deep dyed pessimist, however, let me hasten to add that these symptoms do not alarm me, they only spur me on to urge that a correct diagnosis be made and proper treatment applied. Therefore it is the purpose of this paper to focus your attention upon the fundamentals for the protection of child health and to raise certain questions about our present programs and methods of organization.

Satisfactory community sanitation is a fundamental in any child health program. Trite as this statement may sound to a group of trained health workers, there is ample evidence that there is grave danger of its being under-estimated or forgotten.

Our wonderful strides in the development of methods of control of environmental health hazards during the past quarter century has been almost eclipsed by what we now speak of glibly as the "stage of personal hygiene." We must not let our enthusiasm for new methods lead us to neglect the proven fundamentals from the earlier stages of our health programs.

No program for the protection of child health can possibly succeed which does not provide for adequate control of milk and water supplies as well as proper disposal of wastes.

Our success in persuading every child in America to drink a quart of milk a day would be nullified if the milk were infected with the germs of tuberculosis, typhoid or other milk-borne communicable diseases. Strong, happy, healthy children, built up by systematic practicing of health habits, can be destroyed by a contaminated water supply. Positive health will be seriously handicapped if its little devotees must sit

in overcrowded, overheated and ill-ventilated schoolrooms and live in unsanitary tenements. Therefore our first fundamental for the community protection of child health is satisfactory community sanitation. This means a public health department with sufficient legal powers, a respectable budget and a trained official directing it.

But the highest development of child life demands more than a sanitary environment. It demands that some attention be given to the heredity of our offspring and the health of their parents. The preservation of child life and the promotion of child health requires that certain services be available for 100 per cent of the children of our country. In conformity with our American habit of solving our social problems, the effort to provide adequate child health service has grown up independently under many specialized groups and from a great variety of points of view. The lack of agreement both on methods and relative values of various procedures has been inevitable in the early days. The time has come, however, when a real unity growing out of a pooling of our experiences and resources is both desirable and necessary. It is proposed, therefore, to discuss first what we consider as certain minimum child health services without regard to who can or should furnish them and later to say something of the efficacy of our present methods of organization and operation.

As the first step in our discussion, we will present a brief outline of certain health services which are essential to any well-rounded child health program. For ease of description they have been classified according to the traditional age groupings. It is realized that child life itself does not conform to our ideas of arbitrary, artificial classification.

The striking and disturbing number of infant deaths during the first month of life leaves no doubt about the necessity for a proper prenatal service. An analysis of the causes of these deaths indicates clearly that to meet the situation will require medical and nursing supervision of mothers of all social grades. In addition, educational preparation for motherhood should not await marriage and pregnancy. We should recognize that the time to begin our prenatal service is in our high school courses in home-making. The provision for this service on an adequate scale involves the real cooperation of the public and voluntary agencies and the professional groups.

No greater need exists in our country today than making available for every mother and child modern natal care. It is quite unnecessary for me to repeat the statistical evidence of the unsatisfactory state of this service. We are beginning to have some idea of its seriousness in terms of infant and maternal mortality but we have as yet no glimmering of the amount of maternal and infant morbidity due to poor obstet-

rical care. Any plan for the protection of child health which does not aim to secure adequate obstetrical care for all mothers is neglecting one of the fundamentals. The complexity and difficulties involved in such a service are fully recognized. This, however, does not relieve the medical profession from the duty of raising the standards of obstetrical practice and the public and voluntary health groups from the responsibility of providing adequate community facilities for good natal care.

No argument is necessary to secure the recognition of a good infancy service as a fundamental in a child health program. Notwithstanding the commendable progress which has been made in this line, much remains to be done. Too frequently the well baby clinic for the indigent and the high grade specialist for the children of the rich complete the community facilities. The quality and quantity of the health service rendered to the children of the middle class leaves much to be desired. To meet this situation means education of mothers and medical and nursing supervision of children placed within the economic reach of all.

The comparatively recent discovery of the pre-school child has brought ample recognition of the great importance of this period of life. No completely successful scheme for meeting the needs of this group of children has been devised. The simple continuance of the infancy service is not sufficient. The baby as he develops into an individual forces us to recognize that he has a mind as well as a body. At this point should be added to our physical supervision the beginning of a proper régime of mental hygiene. Health habits can best be inculcated at this period if mothers are taught methods.

At the school age the home divides its responsibility for the child with the public authorities. This makes it incumbent upon the public authority to provide adequate health protection. To this we have now added health promotion. Consequently a school health program, including health supervision and health education, should be considered one of the fundamentals.

Health supervision should include protection against communicable diseases and periodic physical examinations with correction of remedial defects. Health education should mean the teaching of health along modern lines from kindergarten through high school, beginning with health habits in the lower grades, adding informational materials in upper grades and concluding with a well-considered preparation for parenthood in the high school. This involves the real correlation of all the medical, nursing and educational forces in the community.

The difficulties experienced in securing a proper health régime for children in the home indicate that the education of parents in the principles of child health is one of the fundamentals of any community

health program. To be sure many attempts have and are being made to accomplish this by means of lectures to mothers, literature and conferences. These, however, are not sufficient. Efforts should be made to enlist the interest of parents in the serious study of the business of rearing children. This would meet the need of the parents of the present generation while we are waiting for our educational system to include these fundamentals in the training of every child.

This brief enumeration of the necessary health services for assuring our children maximum health will act as a basis for the discussion of the fundamentals of community organization by which these services can be provided.

A well-organized official health department is the foundation of any health program for children or adults. As long as communities are satisfied with part-time, politically controlled, poorly trained and poorly paid health officials, it is futile to talk in terms of a national program for the conservation of child life. We must bend our efforts toward securing a public recognition of the fact that this important public service requires the highest type of trained official who is capable of exerting real health leadership in the community. Such an official would secure proper community sanitation as well as build up an all around health program which would include proper emphasis on child health. This is the first fundamental in community organization for the protection of child health.

The second fundamental in community protection of child health is the provision of a real health program in the educational system. This should include both health supervision and health education. The health supervision, whether it be administered under the board of education or under the board of health, should see that every child is provided with sanitary surroundings, is protected against communicable diseases and is given periodic health examinations. Ample detailed discussion of the health education part of the school program has been provided in other sessions of this meeting. It will suffice to say here that it should be correlated with the health supervision.

The community provision for the third fundamental—adequate medical service—is not such a clear-cut matter. Some plan for complete medical supervision for every child in both health and sickness is clearly indicated. This will require real team work between the physicians and the public and voluntary health agencies. It is hoped that the medical profession will grasp this wonderful opportunity, for if the physicians once get the vision of the possibilities of preventive medicine, they will join hands readily with the public health worker in making it available for all children. The subject of the quality and quantity of

obstetric service being rendered to the women of America is a problem to which the medical profession must give careful attention. Our high maternal mortality can and should be reduced. The responsibility for accomplishing this is a dual one, belonging to both the medical profession and the community. The medical profession must see to it that the standards of obstetrical practice are raised and the community must make available adequate nursing and hospital facilities.

This brings me to another fundamental. No modern community which is planning to protect the health of its children can afford to be without a well-rounded public health nursing service. How shall this be organized? How shall it be supported? What fields shall it cover? One still hears much heated discussion about these questions. Not being a nurse, I am not altogether sure that I would be considered qualified to give an opinion on the technical aspects of these questions even though I do have some fairly definite opinions. I am sure, however, that we must find some way to secure for the individual child the invaluable services of these trained women who have done so much to promote the cause of public health. Further, I am convinced that these services should be conducted on the generalized plan which considers the child as a whole and the family as a unit.

Whether we are ready to accept the recommendation of Professor C.-E. A. Winslow and place this service under the department of health, is questionable. It is one of the fields where the voluntary agency can promote the cause of public health in the community in such a way as to hasten the day when public health officials will be of such a character that there will be no question about where to administer nursing or how it shall be supported. Pending this time, it is incumbent upon the leaders of public health nursing to see to it that proper relationships are maintained between their profession and the health officials and physicians. This is frequently difficult but it is one of the most important problems in the public health field today.

Since I have had the temerity to pass an opinion on technical nursing matters I am emboldened to include another fundamental about which physicians and, particularly public health physicians, are not supposed to know anything, namely, the necessity for properly organized social service agencies in a health program. I am thinking here not merely of relief agencies, important as they are, but also of those character and body building groups such as the Boy and Girl Scouts, the Y. M. C. A. and the Y. W. C. A.

The more I consider this subject, the more it is borne in upon me that we won't really get along very much further with this child health program if we don't begin to think about the child as a whole. He

can no more be divided up into separate parts with safety than the medical specialist can mark off one region of our anatomy and treat it successfully without any relationship to the rest of the body. We may do a fine technical piece of work but our end product will be like putting a Packard engine in one of Henry Ford's productions. So, lest I plunge on into religion, economics and many other influences which are undoubtedly important in child life, I will content myself with concluding our list of fundamentals with a word about coordination.

It is true that this poor word has been worn threadbare during the past five years. We have had numerous painful experiences in attempting to coordinate the work in our own field. Gradually but surely the results of these efforts are beginning to bear fruit. Until now, no doubt has existed in the minds of most health workers that no community program for health protection is sound fundamentally which does not provide for actual coordination of all agencies in the field. This must be interpreted to mean both official and voluntary agencies and does not omit the medical profession. Shall this be a Council of Social Agencies or just a Health Council? I do not know. It will depend upon the size of the community and the character of the problem. I do know that the time has passed when official and voluntary agencies can afford to omit from community programs for child health the machinery for close coordination of their work.

One thought has been purposely reserved for last because of its great importance. We are in danger of fundamental wrong thinking in building up our child health program. In our eagerness to develop our own pet point of view and protect our own professional group we are in danger of letting the child drop in between. The medical man claims one part of him, the nurse another and the educator another, to say nothing of the nutritionist, the mental hygienist, the physical educator and so on and so on. May I challenge every one of you, then, to think through your own program and base it first (if you have not already done so) upon service to the child and second upon any personal or group interest you may have. In other words, let us think from service to organization or group rather than the reverse. For in my opinion what we need more than anything else is a program which will consider the child as a whole, not in parts, one in which there shall be no line between prevention and cure, where group interests will be submerged for the general good and the physical and mental rights of the child shall become the dominant note in a well-rounded National child health program.

DISCUSSION

William J. French, M.D., Director, Child Health Demonstration, Fargo, North Dakota: One of the most important points in the paper we have just heard is the idea that we should work from service to organization. In the past we have done just the reverse. We have built up an organization with the idea that we would adapt the child to the plan of the organization. One of the great lessons that we must learn is that the child is an individual, an individual who is part of a family group, and that that group, the family, is what makes up the body of the citizenry of the country. We cannot bring about improved conditions of child health or child welfare until we find a way to make the child a healthy efficient factor in the family group. He is not only part of the family group now, but potentially the head of a family later on. We must study the peculiarity of the community in which he resides, and then adapt our program accordingly.

If we are going to have good child health, good family health, the family physician will have to begin to function in preventive medicine. He will have to be almost a specialist in preventive medicine, in fact. And we must teach the family groups to take their children to him for advice, and not wait till it is a case for cure.

The Chair: Both our speakers this afternoon have talked of working together as between services, rather than between organizations. Dr. Morgan made a great point yesterday when he said, "If any of you think you are doing uplift work, don't!" That reminds me a little of George Ade's remark in one of his Fables in Slang: "If you want to do uplift work, get underneath."

A Speaker: It is going to be hard luck for some communities, if they have to wait for the doctors to direct them, because there are many places where there is not a physician to be found at all. That is one of the things that enters into the question, and that is sometimes overlooked.

Dr. Brown: I think Dr. Veeder answered that question successfully. Until such time as we are ready to change the present ordinary habit of thought in regard to the doctor, and to remember and realize that the doctor is a human being, who like other men has a wife and children; until we are ready to make the communities possible and worth while for doctors to live in and work in, it will not be possible to get them to leave the centers, or to get them to take the desired leadership. In other words, we cannot do it until we get the work of public health out of the field of political control. What we, as social workers, have to do, is to sell the idea of the proper kind of doctor for the community. Instead of tearing down the doctor's prestige, let us work for this. Let us work from under and not from on top.

A Speaker: What does Dr. Brown consider the most effective method of educating mothers in principles of child welfare?

Dr. Brown: I can only answer like Dr. Vincent: there are some things for which I do not know of any method. We have to apply to the education of mothers the same ideas as to the education of the child. We have been talking about educating mothers, and trying to do propaganda by lectures and conferences. We want some good missionaries such as the lady who asks the question, to interest the mothers, as we found it being done in some groups in the west. Mothers are more ready to accept the education, I believe, than we are prepared to give it. In Oregon, we found a little group of mothers with no contact with any organization, who were meeting week after week, doing a real study course of child health, starting with the child of school age. They were also studying the infant and pre-school child, and had made out a program by themselves.

WILL COMMUNITIES PAY FOR AN ADEQUATE HEALTH PROGRAM?

BLEECKER MARQUETTE, Executive Secretary, Public Health Federation,
Cincinnati, Ohio

Can the public be made to buy more Ivory Soap, more Waterman's fountain pens, more Ford cars? Will communities pay for an adequate health program? It seems to me that the answer to both questions is very much the same. Every Main Street in the country is so crowded with Fords that it seems impossible that any more could be sold, yet the Ford Motor Company goes on increasing its sales. They aren't worrying about whether they have reached the sales limit, and if we as public health workers learn to do our job as effectually and to sell our goods to the public as skillfully there is no sound reason why we should not go on increasing our sales.

It is reasonable to assume that at any particular time there is an absolute limit to which the public will and can go in financing public health work, but certainly we should not assume that we have reached the absolute limit until the evidence is positive.

Those of you who have read Voltaire's delightful satire "Zadig" will remember one episode in the hero's career. Zadig injured his eye seriously. He went to a certain renowned physician of the day. The physician after a careful examination of Zadig's eye pronounced the injury incurable and informed Zadig that he would have to lose his eye. Strangely enough, in a short time the eye got better. The renowned physician was bitterly incensed and he immediately set about writing a long and learned treatise in which he proved to his own satisfaction at least that Zadig should have lost his eye. We public health workers should not make the mistake of trying to prove that we have reached our limit in financing public health work.

The evidence that we have not reached the limit is sufficient to give hope to even the faint hearted. Figures showing the per capita expenditure for public health in 81 cities in the year 1921 throw an interesting light on the subject. They reveal a range in per capita expenditure of from 11 cents in Scranton, Pennsylvania, to \$1.04 in Bridgeport, Connecticut. (This does not include hospital service or garbage and refuse disposal.) In other words, one city spends nine times as much as another city. Yet the people of Scranton are not a different species of human beings from those of Bridgeport. Something has happened in health work in Bridgeport and the cities high in the list of per capita expenditure that has not happened in the other cities. If there is no fundamental difference between these two communities, why should

Scranton not be able eventually to increase its budget to nine times what it is today? Why should it be impossible for any city in the country to get as much as Bridgeport and more?

And although it stands highest on the list, Bridgeport has not necessarily reached its limit. In fact, its Health Commissioner is confident that they can continue to secure their present appropriation and increase it when the necessity arises. This striking disparity in the amounts spent for health work in various cities—and there is almost as great disparity in the amounts that States give to their health departments—offers fairly convincing proof that most of our communities can be made to pay more for public health if we know how to do the job.

It should, of course, be kept in mind that the per capita appropriation to health departments is not a complete index of how much communities are spending for health. In many cities as much money for health work comes from volunteer gifts as from taxation. The city which gives its health department a meagre appropriation may be the one which contributes most freely to its private health agencies. The vast difference in the per capita amounts of volunteer gifts in different communities shows also that the majority of towns cannot have reached their limit in volunteer giving. There is a range in this field of anywhere from 10 cents to \$4.00 per capita.

It is probably true that some cities are approaching the maximum they will pay in taxation and that others are reaching the maximum they will contribute in volunteer gifts. This does not necessarily mean, however, that no more money is to be had for public health work. An analysis of the facts shows that in most communities, and for that matter in States as well as in the Federal government, a disproportionate amount is spent for other government activities as against what goes into health work. An analysis of the per capita expenditure of 187 cities for different government purposes shows that the average city in this group spends \$10.62 per capita for education, \$3.66 for police protection, scaling down to 71 cents for the conservation of public health which stands at the foot of the list. It would seem that public health workers have a reasonably good chance of convincing the communities that public health is not getting its proper share. The same holds true for volunteer contributions. Since it is an established fact that ill health is such a large factor in producing poverty and other social problems which the community has to take care of through volunteer contributions it ought not to be impossible for us gradually to get a larger proportion of these funds for our purposes.

Isn't it rather ludicrous to accept the proposition that we are approaching the limit in the amount of money we can get for bona fide

health work when we realize the vast sums of money that the public throws away each year for tobacco, candy and other luxuries? There appears to be almost no limit to the amount of money people will spend for these things. We spend, it is estimated, nearly two billion dollars a year for tobacco and nearly one billion a year for confections, as compared with about sixty millions a year for public health work. Then, too, the public is throwing away millions annually upon worthless and more than worthless patent medicines, quacks, nostrums and fake cures of every variety. If we could succeed in diverting this amount of money to legitimate public health work that alone would be sufficient funds to allow for as much expansion as we could wisely handle for some years.

The city of Toronto affords an excellent example of what the public health worker can do when he knows his job and knows how to sell his wares. I commend to you a fascinating story by Geddes Smith called "Health Unlimited," in the October issue of the *Survey*. This is the story, Mr. Smith says, "of how one man with vision and a knack for getting things done jacked up a municipal budget and lowered the death rates in a way that carried the whole community with him."

Dr. Hastings took hold of the Toronto Health Department in 1910. He had a budget of \$7,900, or 27 cents per capita. His staff consisted of 75 workers, including 1 public health nurse. After a 10 years' battle he increased his budget until he now gets over \$800,000 a year, or \$1.56 per capita, and has a staff of more than 500 people, including 114 nurses. It has been a wonderfully effective piece of work, nor is it explained by the fact that the people of Toronto are more interested in civic affairs than we Americans. The explanation lies in the fact that Dr. Hastings knows how to produce the goods and how to make it attractive. He is a fighter who knows what he wants and knows how to go after it. You will be interested in the story of how he fought an antagonistic council and won their backing in a man's fight. You will be interested to learn how he won his pure milk fight by proving to the citizens of Toronto that they were paying \$275,000 a year for water when they thought they were buying milk. Dr. Hastings has gotten results. His city has the enviable record of having one of the lowest general mortality and infant death rates among the cities of this continent. No city is justified in assuming that it has reached its limit in getting money for public health until it has done as good a job as Dr. Hastings has.

We should consider, in approaching this problem, the sources from which we get our money. Two have already been discussed—taxes and volunteer contributions. There are two other main sources, endowments and fees charged for services given to clients. Mr. William J.

Norton of the Detroit Community Fund has presented an interesting analysis that should be valuable to the health worker. He estimates that, on the average, we receive for health work, 30 per cent from tax funds, 15 per cent from volunteer gifts, 5 per cent from endowment earnings and 50 per cent from clients' fees. It is Mr. Norton's opinion that in those cities where the tax rate is already high and the per capita in volunteer gifts is large, the most hopeful source of revenue for health work lies in clients' fees. No doubt Mr. Norton's conclusion is sound and we should look forward to making as many public health services self-supporting as possible. On the other hand, experience will show that putting such service on a fee basis is an extremely slow and difficult task.

The question of whether or not we have reached our limit in getting money is rather academic. A much more practical one is how can we get it.

The first step, it seems to me, is to analyze our local situation. How much money are we getting from taxation in comparison with other cities in the country? How much from voluntary gifts? Is there a possibility of attracting more endowments to the public health field? Are we making progress in putting health services on a pay basis so far as possible? When we find the answers to these questions we shall be in a better position to know our next point of attack. In the average community our greatest hope for additional revenue is taxation and voluntary gifts. Any sound program of public health work will be predicated upon the fact that private gifts are best used to promote new pieces of work, to do what government bureaus are not ready or willing to undertake, to provide the stimulus for high standards and consistent programs, to carry on the fight to popularize public health work.

The Committee on Municipal Health Department Practice of the American Public Health Association, in its recent report of a study of health work in our larger cities, outlines the activities and organization of an ideal health department. The Committee estimates that to approach this ideal a per capita budget of \$1.95 is needed. No community in the United States, so far as I know, gives its health department an appropriation of this amount. The Committee points out, however, that in some communities numerous of the activities which the committee recommends are carried out by private health agencies, and that when these are counted in the total, the per capita expenditures in such cities already approach \$1.95. Our goal must be to get for our public health departments increasing appropriations until they can do a first class job. It has been said by some one that social workers and reformers should measure time in æons, instead of in years. Therefore

we must not lose courage if we move forward toward our goal slowly and in the face of many obstacles.

There are certain things which may be accepted, I think, as fundamental in putting over public health work.

First is the necessity for real leadership. Toronto is the best example I know of for "sky-rocketing" public health appropriations. Any one who has had the opportunity to make his own study of Toronto's Health Department will be convinced that Dr. Hastings' extraordinary qualities of leadership have been, perhaps, the chief factor in the Department's success.

Allied to leadership is the necessity for understanding and harmony among the public health forces, specifically, the public health department and the private health agency. Each has its own place and should learn to keep it. It is not within the scope of this paper to discuss the place of each. Many recognized leaders have already done so ably and fully. May I say only that I consider it to be the job of the private health agency to do all in its power to see to it that its public health department has a high class personnel, that it functions efficiently, is scientific in its work and is kept completely out of politics. The private agency should be able to stand forth as the champion of the public health department, and it can do so only when the official department deserves public support. It should not be necessary to assemble an array of arguments to prove that we cannot do the best kind of job in convincing the public unless we can agree among ourselves and fight shoulder to shoulder.

The next essential is an intelligent, well-rounded program. The problem is different in different communities, but the aim must be everywhere the same. We should know where we are heading and work out our route in the most intelligent way we know how.

The support of the medical profession is vital. This task is not easy, yet the way must be found to carry the doctors with us. They have the greatest opportunity of any group in the community to sell public health. The relation between physician and patient is different from almost any other found in the realm of human relationships, and yet the opportunity is largely wasted. The average physician is a poor salesman. He does not talk to laymen in language they can understand. He does not answer simple questions that the average man wants to know, he will not teach him the elements of personal hygiene and how to keep well, he will usually laugh at the patient who asks for a physical examination. He is so poor a psychologist that he drives his neurotic patients to chiropractors and quacks.

The fact that ethical physicians are failing to keep the public with

them is strikingly proved by the way in which advocates of various false theories flourish. The most outstanding example in recent days is the large following developed by advocates of the so-called electronic or Abrams theory. A committee carefully selected by the *Scientific American* has only this month disclosed this theory to be an absolute fake, and yet the gullible public has been fleeced out of millions of dollars by its advocates. This could not happen if physicians learned how to get the confidence of the public. Perhaps our job in bringing the medical profession along with us is as difficult as it is to educate the public, and yet it can and must be done. We must convince them that it is the public health agencies which carry on the fight against cults and quacks, who fight the battle against anti-vivisectionists and anti-vaccinationists, who combat the sale of patent medicines and who in many ways are the friends and allies of the medical profession.

The next essential is a thoroughly good job. We cannot betray the confidence of the public and succeed. Our work must be scientific and efficient.

Finally comes the task of getting the message over to the public. The health worker must learn that it is just as important to let the public know what we are doing as it is to do the job. We cannot wisely go on doing our work quietly, keeping it to ourselves. We must tell and sell the public every inch of the way. We must get into the habit of putting our story in a simple, understandable way, free from technical jargon. The public health worker needs to be something of a publicity expert. He needs to develop the publicity sense, to learn to recognize news when he runs across it, to appreciate the importance of the human interest touch. He should watch the methods successfully used by people who build up business and who earn their living by advertising and publicity. He should know the most striking methods of proving to the public that public health work pays. He must learn how to make every piece of literature count.

There is no field in which more money is thrown away than in the publication of pamphlets and leaflets. Year by year the mass of printed material is increasing. We have to compete with a bewildering amount of printed matter. We are contesting for the attention of the reader against great odds. It stands to reason that the thing that is striking and unusual will win out. One piece that is read is worth a dozen thrown away. The American Child Health Association has done a great service to the public health movement in showing us how to use the printed message.

The daily health column in the newspaper when sponsored by a recognized health authority is a great medium for teaching public health.

It has seen a great development during the past two or three years. It has told the public what the public wants to know. Its effect has only begun to be felt, and as time goes on its value will be recognized as much greater than we believe today.

The health exposition has a great power provided it is handled scientifically and ethically, provided it arises from a spontaneous desire within the community and is free from the influence of the commercial promoter. The daily news item, the radio message, the window display are valuable media.

Yet I believe that we have a long way to go before we discover the best way to sell public health. Few communities have done a thorough job. There is still something lacking in our methods. It deserves the best thought of the best minds in the public health field. So long as the patent medicine vendor, the anti-vaccination fanatic, the chiropractor and all of the rest of the brood continue to deceive the public, we must concede that we have not yet discovered how to get our message over.

Since there is such a wide disparity in the per capita amounts received by various health departments it has seemed worth while to try to get the opinion of health commissioners in cities having high per capita appropriations as to why their communities support public health work. I have asked this question of 17 cities with the highest per capita appropriations, and have received replies from 14 of them. Most of the department heads gave a number of reasons.

Six health officers believe that their success has been in large part due to the intelligence and fairness of the budget committee that allotted their appropriations and to the fact that they have sold them and the rest of the administration on the value of health work.

Five hold that doing an efficient job accounts for their success in getting funds.

Four health commissioners said that the main factor in arousing the public to support health work has been the menace of some epidemic.

Three departments cite the backing of the press, three the support of health and civic agencies, three constant publicity and education, three the fact that the department has been kept out of politics.

Among other factors cited are enlisting the backing of the medical profession, the excellence of the department organization and the competence of its staff, the continuity of the health board, a definite policy and a definite program, strong leadership, convincing the business men of the community that a good health record attracts industry to the community and finally, the general progressive spirit of the city. A number of the health commissioners emphasized the fact that they have

purposely avoided using spectacular methods in building up support for their departments.

It is worth while to quote a few of the outstanding statements by various health commissioners who replied:

1. "I am cognizant that our community is undersold. Our task is to put health up in an attractive package, have the ingredients rightly proportioned and palatable and then tell the world. It will sell and people will want more of it."

2. "We have made a consistent reduction in our infant mortality rate and we have kept the public informed as to this reduction. I doubt very much that with the record we have been able to obtain in this particular, we would ever meet with any opposition in our endeavor to secure funds for its continuance or possibly enlargement."

3. "I rather feel that if we keep on along the lines we have already laid out, looking for no spectacular results but with high standards always before us, that we will or should have no great difficulty in securing funds for the continuance of our work and for its extension when necessary."

4. "The support of the public press is essential, and such can be secured by proving the sincerity of your administration. About ten years ago we requested in our budget one million dollars for the construction of a tuberculosis sanatorium. The leading afternoon paper carried a two-column editorial on the first page of its five o'clock edition every day for two months. The editorials were written by a reporter detailed to this work, who explained in terms which the layman could readily comprehend just what tuberculosis is, and why we needed a tuberculosis hospital. Public sentiment was aroused and when we appeared before our appropriating body the members of the Council literally fell over each other in their endeavor to back up our request. Instead of obtaining one million we achieved two million dollars.

"Our endeavor to get funds for the hospital represented a short intensive drive which resulted in our obtaining what we wanted. The same theory can be as successfully applied to a slow progressive drive to gain public support which must necessarily bring with it the support of the appropriating body, which is always anxious to back up the popular thing."

5. "By closest cooperation with all social agencies, even to the extent of asking various agencies to carry on special lines of work that the department may wish to inaugurate, or is unable to carry on due to lack of appropriation, we have done what we have. The more social agencies that you may have working with you, the more you will have working for you."

6. "I estimate that we should have, for a complete program, about \$100,000 a year, and in due time we will secure that amount, for I assure you that our community is willing to pay for adequate health work."

7. "I have devoted my time for 10 years to public health work and in no place, regardless of politics, has honest public health work not been rewarded by adequate financial support. At the present time it is possible for this department to get any sum of money within reason for public health purposes."

DISCUSSION

The Chair: I think the paper Mr. Marquette has given us is so interesting that I am almost inclined to think he ought to change his vocation for that of a short-story writer. The paper is now open for discussion.

H. S. MUSTARD, M.D., Director of Child Health Demonstration, Rutherford County, Tennessee: Mr. Marquette in the latter part of his paper mentioned the various ways whereby health officers had got appropriations. It reminds me of Dr. Hare of Philadelphia. In discussing whooping cough, he says there are as many treatments as there are doctors practising medicine. I think that is significant. There is no one particular way, I am convinced, of making your community pay for its health work. But each community must be approached from the responsible strategic standpoint. Yesterday Mr. Meyer spoke of the different kinds of communities. One, he said, was a custom community, another was a conventionality community. And therein lies a good deal of the story. Communities have their own personalities, and a method perfectly suitable to Kansas City, for instance, might not be applicable to Richmond, Virginia, not because the people are so entirely different, but because they have got into different habits of thought, not deliberately but by training, by the training of events, so that a certain appeal might be successful in one city where it would fall completely flat in another.

In dealing with appropriation budgets I have found that health appropriations usually run the same gantlet as other appropriations. The same group who vote against appropriations for health will vote against appropriations for good roads, and so forth. On the other hand, the supporter of one move will almost certainly support the other.

In approaching our appropriating bodies or volunteer agencies, we so frequently come before them telling them a story of today, simply today. I believe the only way to give them a true picture of our efforts is to make a request for an appropriation today as a part of the long upward fight that is going to be carried on. It is most unfortunate, I believe, to say in effect, Give for this year, and let next year take care of itself.

I do not believe we have always, all of us, been entirely honest with the people whom we have approached upon such matters. We have promised them frequently the moon, and then have handed them out the proverbial green cheese. Health work is so thoroughly established now that even though we might not be essentially honest it pays to be so in fact. Let us, we must, give up the tendency to promise more than we can absolutely produce.

The next thing is to get the backing of official agencies by interpreting your work in terms they are able to understand and appreciate. I was talking to a hard-headed business man the other day. He asked how my particular demonstration was getting on. I told him that I was pretty well satisfied. Then he said, "Do the people understand what you are going to do?" He said he looked at it from the point of view of debit and credit. "You know," he said, "as soon as they really understand, you won't need to stay here any longer."

The Chair: It is encouraging to know there are a number of communities that are really spending what most other communities would consider a considerable per capita on health work.

THE RELATION OF THE PRESS TO COMMUNITY CHILD HEALTH WORK

R. H. HIXSON, Managing Director, Public Health Association, Oklahoma City, Oklahoma

Child health work is primarily a campaign of education—education of the masses instead of any special group. Such a campaign is one of publicity. It requires salesmanship to succeed—salesmanship of ideas. Selling an idea to the public is the most difficult task in the realm of publicity. It is far easier to sell a particular article.

A right relation to the press is the heart of the whole program. There are various types of publicity—the spoken word, pamphlets or leaflets, the screen, poster advertising, and the press. The greatest of these is the press. Put yourself in the position of the average man for the moment. You have no children, or if you have they are normal as far as you know. You have never had your attention directed to their health in any forceful manner by serious illness, death in the family, or noticeable defects. Someone hands you a leaflet as you pass along the street or by a fair booth. It goes in your pocket or drops to the street. You pass a beautiful billboard which asks you: "Is Your Child's Birth Registered?" or "Have You Given Your Child the Schick Test?" It makes no lasting impression. A lecture is given on some phase of child health. Unless you have been wanting some specific information along this line you don't go. Pola Negri at the Criterion is more interesting. A health reel is flashed on the screen and you take this occasion to engage your neighbor in conversation until the feature film once more attracts your attention to the screen.

It is a fundamental principle of psychology that only such a stimulus as arouses in us some related experience will attract attention—the law of "associating neurones," I believe. Now please don't understand me as depreciating in the least these other phases of publicity. I am to talk on the "Relation of the Press to Child Health Work." I could talk of pamphlets, their set-up and distribution, or of poster advertising, with equal belief in their effectiveness among certain classes. But the point I make just here is that first of all and most fundamental in attracting interest is the barrage of press publicity. Afterwards, for those who have developed a desire for more information, we may make effective these other media of publicity.

Now, Mr. Man of the Street, let's see what your mental processes are in relation to our child health campaign. You have just left your day's work, grabbed a copy of the *Post Dispatch* and turned eagerly to the sporting page to see who won the game this afternoon. Then you

note that it was a benefit game for the local tuberculosis association which has an open-air camp for kiddies, and that fresh air, abundant, wholesome food, with rest and recreation are essential for preventing tuberculosis in children. You can't help reading some health gospel because it is so connected with the game in which you are interested.

Or at another time the local health organization has a campaign for breast feeding. You don't care whether breast feeding or bottle feeding is best. You haven't any children or they are all grown. But you are interested in your Mayor because you voted for him or against him. So, when you hurriedly scan the columns to see what interests you and on the front page see a picture of the Mayor shaking hands with a local doctor or nurse at the entrance of a child welfare station, you wonder what has happened. Is someone hurt, or is the Mayor patronizing these people for effect? You read the accompanying lines to find he is saying that the organization is contributing to the future stamina of American citizens by teaching mothers to nurse their own babies. And you find that thus babies will be stronger and fewer of them will die. You remember that because your Mayor said it. If you are one of his admirers you accept it. If not, you doubt it and at once seek more information. When you have a baby in your home or when a neighbor or relative has one you lend the weight of your influence to have the parties concerned at least look into the matter. You probably ask your physician, at the right time, what he thinks.

Newspapers, realizing this fundamental principle of psychology, scatter advertisements pretty well along with reading matter, except "want ads." These have their own compelling influence and do not have to be sugar-coated with news.

There are three kinds of press publicity—editorial, news, and paid advertising. The first expresses the editor's personal opinion. This space cannot be bought at any price. Great care is taken by the paper to avoid on other than the editorial page expressions of opinion not definitely attributed to some person in connection with an event of interest to a number of readers. This explains why much of the material submitted by local workers fails to appear. It is argumentative or editorial, and it can't be both news and editorial. The report of a meeting is news and what someone of note says, is news. If the report of a meeting or of a month's activities is submitted with someone's comment it "gets by" and you have given the public some information as news. News is narrative. It chronicles something that actually happens. (It may be made to happen for its effect, but it essentially is a story of something that has or is expected to occur.) Almost anything you say, expressed in any manner, will be accepted as a paid advertisement.

None of us like to feel that we have been victims of propaganda. Pure propaganda can never get news space in any reputable newspaper. It is not news, it is advertising. And it is doubtful if propaganda advertising in the press is worth the cost, unless sufficient display and illustrations are used to compel attention. For example, note the ordinary half page ad for an automobile—a beautiful country scene which invites one into the great out-of-doors for a picnic or a cross country drive. The particular automobile is more or less incidental—it is a good car for the purpose, with four wheel brakes for the sharp mountain curves and balloon tires for smooth riding. The whole layout is planned with a view to attracting interest, to luring you out into crisp fall air, to making you want to drive and drive. And the car pictured is a good car for such a purpose.

Or here is another display. An economy car. Cheapest first cost and cheapest upkeep. This ad is not intended to appeal to everyone. It selects its strongest point and plays that up. Now that is what we have to do in child health education—select our strongest point and play it. Always play your high trump. The tuberculosis campaign has harped on the idea that consumption is curable and preventable, with results known to everyone. The slogan you take, of course, depends on your program. A Maternity Center may use the idea “Nurse Your Baby,” and show pictures of husky, rosy-cheeked babies who have been breast fed. It is not necessary to show the contrast. That, in fact, is likely to detract from the main idea.

Now these same principles regarding paid advertising will hold for press publicity of any kind. First attract attention to your message by associating it with something already interesting. Make it brief, snappy. Use the fewest words possible. Remember that scarcely anyone will read arguments and that he who wants complete information will seek one of your booklets. Have just enough “body” to your news item, ad or editorial to sustain the reader’s interest sufficiently to make him favorable to your project. Then put in a punch. If you want to educate him further tell him where he can get additional information. If you want a donation, tell him that “he who gives promptly gives doubly,” or give him some idea calculated to bring quick action.

What we have to do in a child health campaign is to interest all the public—some in giving money, some in giving thought to the protection of infancy, some in giving attention to the physical examination of their children—and the press is our agent for this purpose. All the other forms of publicity are for those already interested and desirous of special detailed instructions. It is through the press, which the man in the street sees and in which he is already interested, that we are going

to extend our program to the disinterested, by associating our ideas with the ideas already commending themselves to his interest. No publicity can be worth much that is not prepared by one who can place himself on the street with the busy worker and visualize his interests.

Discussion

The Chair: I may say that our last speaker had a subject, and a capacity to talk about it, that might well have occupied the entire time of our session this afternoon. I regret that there was so little time available for him, and am sure that all here share in that feeling.

Miss Sally Lucas Jean: The dominant note in Mr. Hixson's paper demonstrates very thoroughly the need for making an appeal which will be one that is an intensive and a natural one. He has dealt chiefly with newspaper publicity. The press offers so tremendous an opportunity for telling our story that its power is almost incalculable. We also of course have our folders and our pamphlets, and they are less expensive than paid advertisement. Mr. Hixson thought paid advertising of comparatively little value, and that the work must be so good and so interesting that the newspapers would be glad to carry it.

When it is necessary to prepare a special publication, as it sometimes is, other material has to be kept in mind. Be sure that just such a publication has not been brought out by some group doing other work. All the publications are prepared by experts, the type of individual who is out of the reach of the local group usually can only be secured at the center. Consequently one of the most important factors to consider in our localities today, before preparing material, is this certainty that the material has not been already prepared by some national or some other local group in better form than we can produce it ourselves.

Then, if you must prepare your material yourself, be sure you know your audience, be sure that there is accuracy in your statements, and be sure that the layout is made by people who really know their subjects.

We are inclined to accept the word of the expert in this field or that, sometimes, and then to find that the people who know the subject do not always know how to tell the story. So we want to be sure that the story, the subject, is presented in right form.

An important asset is the use of local celebrities in connection with our publicity. Then the question of the appearance of our material is important—to have something that is what one cares to look at, as to color, form, design, or printing. You see yourself at once slipping into your pocket, or carrying home with you, a thing from your busy office desk, that looks attractive, that looks interesting. There is a tremendous factor there, to which we have hitherto given but insufficient attention. One of the things that I think is very important is to have on your local board an expert who will serve in this direction as freely and as completely as the other technicians. We have found in the national association that it has been possible to secure expert advice from advertising people if they are given a position of sufficient honor and importance. With such consideration, which is entirely proper, they will serve, and serve gladly. I would like to ask this audience in making up their committees to think how they are going to tell their story to the public, whether they are going to tell it as well as it might be told, and whether they would not do well to be quite sure that they have someone who knows the subject, and not only knows the subject but knows how to get it over to the public.

JOINT RESPONSIBILITY OF PUBLIC AND PRIVATE AGENCIES AND OBLIGATIONS OF COMMUNITY IN OBSERVATION OF CHILD HEALTH PROGRAM

ANNIE S. VEECH, M.D., Director Bureau of Maternal and Child Health, State
Board of Health, Louisville, Kentucky

The health and welfare of the children of the United States is a community, a state and a national responsibility. These children are a charge not only of all the public, but of the private agencies whose interest and strength is in citizenship. We find all sorts of groups studying the child, his inheritance, environment, psychology, habits, his possibilities. For are not our children even before they are born potential citizens? The United States is a great and expansive country, harboring within its borders many types of different kinds of people. The financial resources of every state, as well as the people and the health problems, are so varied that it would be impossible to handle any two alike. Some of our old New England and Southern States are most conservative, bound by many traditions, and look askance at some of the newer methods. They must not be expected to grasp so readily new ideas, as will the young and progressive Western States. Old age never sees with the eyes of youth. The fundamental needs and obligations of all communities are the same. The death rate of the infant and the pre-school child is everywhere too high. Little children are growing up with physical defects uncorrected, leaving them unfitted to grasp available educational opportunities in childhood. Many are failing to reach their highest possible adult development. The least we can hope to do is to give to every child a chance to attain through environment, health and education his best development. Each community is a problem unto itself, and it is only as it is awake to its responsibility that we may have any hope of its children.

Right here comes the responsibility and opportunity of public agencies, such as State Bureaus of Child Health. Inasmuch as I have been asked to speak on the subject of the joint responsibility of public and private agencies in the observation of a child health program, I must give you what I have learned from the experience I have had in a statewide program reaching into every type of community within my state. It is impossible for the limited personnel of a state organization to continue to carry out the detail of established child health work in every community; nor would it be good for the community if it could. As a trained group, the State department can show the local people the need of improved conditions; they can assist in the organization of the community and show them how to carry on the work. But it has

failed in its work if it has not inspired the community to do for its own children.

In looking toward success in child health work, the interest and help of all private and public agencies must be obtained, the most important of which is the local medical society. The advice and help of the medical profession is essential to any health program. We have found our physicians our unselfish and valiant bulwark. Those who fail to avail themselves of their aid make a glaring mistake. Next in importance are the men's and women's clubs and all religious organizations. Often the rural church is the only community center, and its cradle rolls are a good beginning in any community. Close ties should be formed with town and county boards of education, so that the standards of health teaching in the schools may be the most approved. In making the teacher our ally, the child in the school, the pre-school child and the home are benefited. Back of the teacher is the normal school, and here again the State health department can cooperate, by getting these schools to adopt the right standards of health teaching for teachers. Included in the groups of women's organizations is that most valuable one—The Parent-Teacher Association. It is comprised of the home-makers who want the school fit for the child. Through the Bureau of Child Health they are learning how to make the child fit for the school. Then there are philanthropic and industrial organizations—some of which are doing good child health work, and others only groping, mistaking sick nursing for health work; these can be persuaded to employ nurses trained in health work. The county newspapers are always generous and gladly carry weekly talks on child health furnished by the Bureau of Child Health. Also the cooperative marketing magazines, which go into the rural homes of landowner and tenant, carry a page on child health. Through kindness and fair dealing, through unfailing courtesy and helpfulness, pleasant relations are maintained with all these organizations, each organization learning the joy of comradeship in service.

The General Federation and the State Federation of Women's Clubs are deeply interested and cooperative in child health work. The Director of the State Bureau of Child Health gives an annual report of the work of the department before the State Federation meeting. The Bureau offers speakers on child health to all organizations. They are kept acquainted with the activities of the work, all of their demands are met and their help is sought. The Bureau of Child Health cooperates with county health nurses, Red Cross nurses and county health units, by supplying them with child health literature, by assisting them in organizing their communities to make a survey of all pre-school chil-

dren and by helping them to establish permanent child health centers. These surveys are made by local club women, who also act as conference aids in the child health centers. Through this intimate connection with the work their interest and support is held. It would have been impossible to have done the work unaided, which has been accomplished by this varied and large number of groups. It is fine and enheartening to see how splendid each group is.

In counties where there is no health nurse, through cooperation with boards of education, men's and women's clubs, churches and local physicians, the Bureau of Child Health puts on demonstrations, examining all the children,—school, pre-school and infants—in the county. Often a health pageant and an exhibit of health posters are part of the program. This leads to interest in better health, the result of which is the organization of a local health league and the employment of a health nurse. Participation in financing the health nurse may include state aid, funds from County Boards of Education, men's and women's clubs and from the Red Cross. One satisfactory way to encourage interest in child health is to hold child health conferences where children are examined and weighed and parents advised on child health problems, at community, county and state fairs.

The success of child health work depends on the development of a community conscience as to its responsibility to its children. Many communities are financing all of their health work; many will never be able to do this alone. The children who live in these communities are American citizens, who will be expected to defend the flag of our Country if need be. Whether they are born in a wealthy or a poor community or state is not of their choosing. Few of our states have great enough wealth to meet the needs of its children. Had it not been for the federal financial aid, of which most of our states are now availing themselves, it would have been many more decades before most of the states could have accomplished as much as they have in the last two years. Through this federal aid, state health departments have been able to arouse an interest in maternal and child health. Self-respecting citizens knowing the need and hungering for authoritative teaching in matters pertaining to child health, are, to the limit of their resources, responding to the demand for help in carrying forward the plans laid out by the state health department. We must pool our strength and our resources and work together for the love of our children, and not for our own "credit." I would say that lack of self-interest in all organizations working for the good of children is a keynote of success.

AMERICA'S GREATEST ASSET—HER CHILDREN *

S. J. CRUMBINE, M.D., Director of Public Health Relations, American Child Health Association, New York City

The price of wheat, the yield of corn, foreign markets and the cost of living are burning questions of the day. They all touch upon the subject of national prosperity and determine our ability to do worth while things.

There is another item close to our hearts yet lurking in the background because of its very nearness that is of vital concern to each and every one of us. The future progress of this country depends upon it more than anything else. I speak of the American child. He is the substance out of which the next generation is made. Why concern ourselves about him? Can he not take care of himself? Will not his parents look out for him?

The reason we puzzle over the child and hold meetings to discuss him such as the Annual Meeting of the American Child Health Association now in session in Kansas City, goes back to the fundamental desire of all of us to progress. It is because we see situations that are not right, because we see practical ways in which the world may be made safer for your child and mine, that we write and talk and discuss plans for putting these ideas for betterment into effect.

You, fathers and mothers of Kansas City, are the beneficiaries of these efforts.

Perhaps you know of some one who has lost a child from diphtheria. You do not want to lose yours. If plans can be worked out for preventing such distressing occurrences in the future, are you not willing and eager to know of these plans?

The American Child Health Association has in the past year visited every city in the country having a population of between 40,000 and 70,000 people in order to learn what the small city is doing to protect its children. There are 86 cities in this group. Diphtheria can be prevented by immunizing children before they enter school. Forty-six cities are making use of this discovery. In one city 4,900 children were thus safeguarded against diphtheria this past year. It is by such steps that we can prevent the 6,600 cases and 550 deaths that occurred from diphtheria in these 86 cities last year.

We find that in many places milk, the staple article of a child's

* A radio talk given under the auspices of the Health Conservation League as their weekly Radio Talk.

diet, is not safe to drink. Only 19 out of 86 cities have taken steps to make milk safe, that is, by pasteurizing at least 90 per cent of the supply. Unless safeguarded, milk may become infected by sick people handling it and thus transmit disease broadcast to many consumers, most of whom are children. Sixteen epidemics traced to an infected milk supply have occurred in this group of cities in the past five years. Every city should pasteurize its milk.

What will help your child most, a knowledge of health or a knowledge of geography? I believe in teaching geography but I also believe that one of the greatest gifts the public schools can bestow on your child is a desire to be healthy and a knowledge of what to do to keep healthy. Only eleven of these 86 cities have appointed directors of health education in their school systems.

It is by hammering away at bad things and pointing out good health practices that we make headway. Twenty years ago the common drinking cup was seen everywhere in our school buildings. The public has responded to health suggestions by banishing the common drinking cup. Only 13 out of 900 schools visited in the recent survey still had the tin dipper resting in the water pail.

There are two clear-cut health responsibilities resting on every one of you fathers and mothers. The first is the health supervision of your own children. The second is your collective interest in the health of all children in the community. First as to your own responsibility: Have you had your baby vaccinated against smallpox? What time do your children go to bed? Do you yield to the childish request to go to the movies several nights a week or do you turn down these temporary bits of pleasure for the more substantial and lasting pleasure of long hours of sleep? Are you living from day to day or are you preparing your child for the "long pull," a lifetime of health? It is up to you today to decide whether to make or break the well being of the next generation. The greatest heritage you can bestow upon your children is far sighted discipline in daily health habits, and in protection against the disabling diseases.

Next, your responsibility as a member of your community: Do you insist upon a safe water supply? Do you believe in the protection of your milk supply? Do you make clear to your governing bodies that you want in your health department people who know their business, people who are not mere politicians? Do you believe in health supervision and health teaching in your schools? Do you believe in the education of mothers in the care of themselves and young babies through the medium of public welfare centers and clinics?

Of course, all these things cost money. Will you back up your

officials when they charge these important matters in your tax bill? This is the crucial test of your devotion to America's children.

The death rate of our country today is only two-thirds what it was in 1900. Our baby death rate has been cut in two in this period. This did not just happen. It came about by putting into practice the knowledge of healthy living.

So that America may still better serve humanity, I propose to you the toast—Better Health for Uncle Sam's Children.

DISCUSSION OF SOME SPECIAL ASPECTS OF CHILD HEALTH WORK

*Presiding, MRS. WALTER McNAB MILLER, Chair-
man of the Department of Public Welfare, General
Federation of Women's Clubs, St. Louis, Missouri*

1. Findings of Survey of 86 Cities.

*GEORGE T. PALMER, Dr. P.H., Director of Re-
search, American CHILD HEALTH Association*

2. Practical Application of Findings of Survey of 86 Cities.

*S. J. CRUMBINE, M.D., Director of Public Health
Relations, American CHILD HEALTH Association*

3. Report of the 1924 Health Education Confer- ence at the Massachusetts Institute of Tech- nology.

*PROFESSOR C. E. TURNER, Department of
Biology and Public Health, Massachusetts Insti-
tute of Technology, Cambridge, Massachusetts*

4. Other Reports of American CHILD HEALTH As- sociation Activities.

Conditions in the Far West.

*ELNORA THOMSON, R.N., Director, Far Western
Extension Office, American CHILD HEALTH As-
sociation*

May Day for Child Health.

*AIDA de ACOSTA ROOT, Director of Promotion,
Associate Director of Publication, American
CHILD HEALTH Association. Report read by
MISS CRANDALL, with introductory remarks*

DISCUSSION OF SOME SPECIAL ASPECTS OF CHILD HEALTH WORK

Presiding: MRS. WALTER McNAB MILLER, Chairman of the Department of Public Welfare, General Federation of Women's Clubs, St. Louis, Missouri

A slight change of program has occurred in this morning's proceedings. We shall hear first Mr. Walter Whitson, who is the chairman of the Kansas City Chapter of the American Association of Social Workers.

Mr. Walter Whitson: The particular matter I wish to bring to your attention very briefly is the relation of the American Association of Social Workers to the Child Health program. In that association we have the laity coming together with the representatives of three professions—the old and well-organized medical profession; the modern profession of nursing; and the profession-in-the-making of social work.

The reasons for the existence of an Association of Social Workers are much the same as the reasons for the existence of an organization of the medical profession. The objects of the American Association of Social Workers are: to help to develop the things that social work needs if it is going to be a profession; to improve standards; to work out together the things social workers must work out if they are going to have the standing to which we think they are entitled in the community.

The initiatory work has been accomplished. We have taken the compass for our sign, because the Association is aiding to chart the way, the social way, along the technical and other lines which so greatly need charting.

We appeal to all those who are eligible to this Association to become a part of it, to help in building up the profession of social work, which, as it is commonly known now, may include anything. If we are going to be a success as social workers we must narrow the field.

Information about the Association, its aims, and its achievements so far, and the conditions of membership will be sent on application to the Association, 130 East 22nd Street, New York City.

We hope that those of you who may be eligible will participate in this movement, and give us your help and advice toward making social work what it should be, helping us through the professional association of which you may be a part to bring about the standards and status that social work should have.

The Chair: Before beginning our regular program, may I in a few words explain why the General Federation of Women's Clubs was asked to send a representative to preside over one of these meetings.

The General Federation of Women's Clubs is an organization composed of about three million women, organized by states, by districts, by cities, by counties, and by local clubs. All of these have a general program, which is sent out from the Headquarters, furnished by the Department of Work through their Division Chairman. In the Department of Public Welfare, we have the two divisions of Child Welfare and Public Health, representing so many different women and so many shades of opinion, it is very necessary to have some standard program to give out for the various programs of work. We therefore conceive it to be our job to find the best standards that are being worked out by official or semi-official agencies, to interpret them to the different communities, and to ask the women who have had these standards given to them to help insofar as they are citizens and voters to translate the programs into official plans that can be carried out permanently. We, in the General Federation, are helping to make five per cent of public opinion, and that is the reason why the Federation has been asked to participate in working out this program with the American Child Health Association. That Association is the largest, the best known, and the one that is doing the most remarkable work for making standards for child welfare, so we are not only very glad for our own needs to come here this morning, but we are glad to place all our forces at its disposal. The Federation exists for work—it is not just a tremendous machine running a pin-wheel, but a tremendous machine equipped to start efficient action.

Coming to the program of the morning, the first topic we are to consider is the Findings of a Survey of Eighty-Six Cities. Dr. George T. Palmer, who is to speak on this, has been the Director of Research in the Detroit Municipal Department, and before that, with the New York Committee on Ventilation, did very wonderful work. I notice that the American Child Health Association seems to search out in every part of the country for the most notable people to make notable contributions to their work.

I have great pleasure in introducing Dr. Palmer.

A PRELIMINARY REPORT ON A SURVEY OF CHILD HEALTH ACTIVITIES IN EIGHTY-SIX CITIES

GEORGE T. PALMER, Dr. P. H., Director of Research, American Child Health Association, New York City

We have recently been privileged to scrutinize the activities, public and private, relating to child health in all the cities of the country with populations between 40,000 and 70,000. According to the 1920 census, there are 86 such cities located in 31 States.

We have observed these cities very largely through five pairs of eyes and ears. Our observations were made over the period from January to June, 1924. Approximately a week was spent in each city.

Although the analysis of this information is far from complete at this time, it is clear that there are many things in health work that are not being done that should be done. There are many things that could be done better. We recognize, however, that each community is the master of its own destiny. There are many local problems of existence and growth which claim primary attention. A visitor unacquainted with all the details is not in a position to condemn outright because the measures for the preservation of health are not as complete as they should be.

We ask you to receive what we have to say not as destructive criticism but as an inventory of facts.

It has been the purpose of this survey to secure comparable facts. Incidentally the knowledge of these facts will enable the American Child Health Association and others interested in public health to serve best the interests of American childhood.

A child health survey is not a simple matter. A schedule of questions must first be prepared. These questions must be to the point. The answers should be direct and protected against the personal idiosyncrasies of the surveyors. The people who make the survey should be obsessed with a desire to obtain the truth. They should have had a background of training and experience that will give weight to their recorded findings. The surveyors should have a common understanding of the ways of securing information and the real meaning of the questions. In this way only it is possible for a number of individuals to secure information which is truly comparable.

We have endeavored to incorporate these safeguards in our survey.

The choice of the eighty-six cities was dictated by several considerations. Comprehensive information was needed, therefore all should be cities of a certain size. A committee of the American Public Health Association had completed a survey of health departments in cities of

over 100,000 population and the United States Public Health Service was about to widen this to include all cities over 70,000. Less is known about the smaller city, although it is at the very stage of development where municipal housekeeping begins to take the place of unrelated individual endeavor.

There is wide diversity in the complexion of these eighty-six cities. The mill city, the educational center, the state capital—each is represented. There is the old city of the eighteenth century and the city as lately born as the twentieth century. There is the satellite city which glories in its proximity to a great metropolis and the city off by itself on the great plains. One city has 47 per cent of its population of foreign birth. In another, practically all are native born.

We have set out to discover what communities are doing to preserve and insure the health of childhood. We have asked also some questions of the children themselves.

First let me tell you about the children. Thirty-five thousand school children have frankly confided to us their daily habits. All of these children are in the fifth grade. This gives us an unusual opportunity to make a fair comparison of child habits in different sections. We asked them not what they generally do but what they did on the previous day. This gives us a fairly accurate answer, for memory is much more exact for the previous twenty-four hours than when generalizing. We recognize that our facts are only as accurate as the truthfulness of the replies, but a number of checks which we have conducted indicate reasonable accuracy.

It is not mere fiction to speak of these 35,000 children as one composite American Child approximately 11 years old, and as the replies to these questions are spread over a period of five months, we may be pardoned for relating these habits to what is occurring at present. Please understand that this average child I am about to describe is a hypothetical case. He does not exist as such. When I say the average child drinks a glass of milk you will understand that actually some children drink no milk and others drink five glasses a day. The average, however, does give one a picture that can be visualized.

This 11-year-old school child, a resident of our smaller cities, went to bed last night at 4 minutes of 9.

He arose this morning at 5 minutes after 7.

He thus had 10 hours and 9 minutes of refreshing slumber.

He had a substantial breakfast in which bread and butter, cereal, milk and an egg were the main items.

During the entire day he drank 1.4 glasses of milk.

In the last week he has had one bath.

He brushed his teeth on five out of seven days.

He played out-of-doors after school on six of every seven school days.

He has been to the dentist once in the past two years.

In other words, he is a fairly respectable child and would undoubtedly hold his own in any international contest in this field. He does not drink enough milk, however, and he could have his teeth looked over profitably at more frequent intervals.

So much for the average child. Now let us separate this child into his 35,000 constituent parts.

Seventy per cent were in bed before 9:15. Seven per cent were still up and about at 10:15. Cities show wide differences in these retiring habits. In one, 86 per cent retired last night before 9:15; in another only 46 per cent had pulled up the covers at this hour.

As to hours of sleep, 71 per cent had 10 or more. In one city, however, only 54 per cent of the children enjoyed this number of hours of repose.

How much milk should a child drink each day? Some authorities say four glasses as a minimum, others two glasses. Let us see how many had at least three.

Only 38 per cent of these children drank three or more glasses of milk yesterday and one out of every five children drank no milk at all.

Coffee, coffee substitutes, and tea interfere with milk drinking. The average child who does not drink any coffee consumes almost a pint of milk daily.

The child who drinks two or more cups of coffee consumes less than a quarter of a pint of milk.

Thus does our first broad glimpse of American childhood stand before us, his health attributes and his deficiencies revealed.

At the earliest opportunity we shall give to each school superintendent three sets of figures, those for his own city, the grand average of all cities, and those for the best city.

The above is what the school child does. Now let us consider what the community does. Sixty-three cities feel a community responsibility for their babies as evidenced by the establishment of infant welfare educational clinics. This is frequently only a beginning and not many babies are reached but even so this is better than no provision at all. The public health department has charge of this work in 37 cities. Private agencies conduct the service in 43.

Prenatal clinics were found in 44 cities, half of these being under private supervision. In 30 of these cities it appears that about 8 per cent of mothers attend the clinics.

Midwives assist in bringing many babies into the world. There is opportunity for the unsupervised midwife to cause much unnecessary suffering and illness. Many states have realized this and provided for the registration and training of midwives. Fully half of the cities reached by our survey apparently have made little effort to safeguard mothers by exercising careful supervision over the practice of midwives.

Two cities have officially recognized the existence of the pre-school child by establishing a clinic exclusively for his benefit. He is admitted to the infant welfare centers in 29 other cities.

Sixty-one cities have day nurseries, 49 of which have made some provision for medical supervision.

The establishment of a board of health marks the beginning, at least, of official attention to health matters.

Sixty-eight cities possess a board of health. In the other 18 the city commissioners or council act as a board on occasions.

Forty-five cities are employing full time health officers.

The personnel of health departments varies rather widely, 1 city having 27, another only 3.

The public health nurse is a recognized institution. Eighty communities look to her, either through public or private agencies, for advice and care.

One of the first essentials to clear-visioned child health work is a simple accounting system. One must know the number of births and deaths and the causes of death. Gains and losses measure progress and progress is stimulating. Sixteen of our cities are not in the birth registration area where records are of sufficient completeness to be officially recognized by the United States Bureau of the Census. I am not aware of any state that does not require the registering of an automobile. Is it too much to ask that babies have equal consideration?

Three cities are not in the death registration area.

Even within the registration area, however, there are cities which apparently make little use of their human bookkeeping figures. It may spare our feelings to be oblivious of our health status. This seems hardly a legitimate excuse, however, for a city of the United States.

The reporting of communicable disease is far from perfect. In 27 cities the records show actually more deaths from tuberculosis than people sick with the disease. Obviously this is an impossible account of what actually takes place.

In spite of this lack of knowledge of the basic facts, 71 of the 86 cities have made some community provision for diagnosis and supervision of home conditions of the tuberculous.

Children are receiving care at tuberculosis clinics, the ratio in 30

cities showing 2 children receiving attention for every 3 adults.

Forty-one cities, however, show no local provisions for hospital or sanitarium care of the tuberculous. This does not necessarily mean a neglect of this work because there are often state and county institutions which meet the need. However, this is a matter that should be given more attention than it has received.

Open air classes for children exposed to tuberculosis are present in 19 cities.

Six cities were unable to tell us how many deaths occurred from scarlet fever in 1923.

There are some diseases against which, at the present time, humanity has little or no effective protection. There are other diseases which are absolutely controllable if the knowledge we possess is applied. Vaccination protects against smallpox, yet the children's replies indicate that only 71 per cent of fifth graders have been successfully vaccinated against smallpox. This leaves 29 per cent as inviting fuel for epidemics. One city shows but 16 per cent of fifth grade children vaccinated. If the proportion indicated by the 35,000 children holds good for the country at large we shall have in the course of time thirty-two million people in this country ready prey to the most easily preventable of diseases. This is a lost opportunity in our health preservation program.

Approximately 550 people, mostly children, died from diphtheria in these 86 cities last year. It is estimated that at least 6600 experienced the disease. We have reason to believe that the means are at hand for placing diphtheria in a class with smallpox as a prevented disease. It would seem as though cities would gladly and promptly make use of such means. We find, however, that only 46 cities have begun to immunize their children with toxin-antitoxin. Eighteen cities reported that no immunizing was done to their knowledge. Twenty-eight cities could not give us any information on this score. It is pleasing to note, however, that one city immunized 4900 children during 1923.

The schools are reasonably sanitary. The common towel is wearing out and the tin dipper is badly dented. Nine hundred schools were visited. The common towel was visible in only 10 and only 13 schools still cling to the common drinking cup.

Ninety-three per cent of the schools now have inside toilets. Nine out of every 10 impressed the surveyors as being "clean." About 1 out of 5 schools still need more hand washing facilities.

We have discovered only 11 directors of health education in the schools although there are 71 directors of physical education.

School medical inspection of a sort exists in 82 cities. Four have no medical inspection. There are school nurses provided in 62 cities.

Health teaching is slowly finding its way into the schools although there are all varieties, to be sure. Forty per cent of the schools have set aside definite periods of time for health instruction, but better still there is evidence of an initial effort to teach health through the medium of other subjects in 57 per cent.

At least a third of the fifth grade school rooms visited had height and weight records conspicuously posted.

The teachers find themselves embarrassed in teaching health. They are anxious to have children drink milk regularly but this habit is a questionable procedure in some cities. Only 19 cities have pasteurized their entire milk supply or at least 90 per cent of it. In 31 cities less than half is pasteurized. Eight cities do not seem to know much about the milk supply—at least our surveyors could not find any one who would admit such knowledge. This is the protection given the milk supply in spite of the fact that 16 outbreaks of communicable disease have been directly traceable to the milk supply in this group of cities during the past 5 years.

This is a preliminary report. Our final report will not be ready until after the first of the year. There is much analysis yet to be done in the preparation of this final report.

At this stage our impressions of the status of child health in this cross-section of the country may be summed up as follows:

- A—Everywhere there is a budding consciousness of a community responsibility for the health of childhood, yet after all practice is trailing along twenty years behind existing knowledge.
- B—Cities are wasting money by not making more use of technically trained personnel for a technical job.
- C—The neglect of human bookkeeping is distressing. One cannot imagine a business concern being conducted with so little regard for records.
- D—There is not enough “get together” spirit. For the best interests of childhood business associations, social clubs, welfare associations and public agencies should bend every effort to cultivate mutual acquaintance, respect, confidence and support.
- E—Mushroom growth of health-promoting activities should give way to a definite plan of action.

Somehow or other we have a feeling that Uncle Sam’s children are worth this consideration.

In conclusion we desire to express our sincere thanks to the many individuals in the cities visited for the cordial reception given our surveyors and for the aid in making these findings of practical value.

This survey is already becoming productive and you will hear shortly of constructive efforts that are being made to assist cities in effective child health advancement.

PRACTICAL APPLICATION OF THE FINDINGS OF THE SURVEY OF EIGHTY-SIX CITIES

SAMUEL J. CRUMBINE, M.D., Director of Public Health Relations, American Child Health Association, New York City

At the annual meeting of the British Association for the Advancement of Science held recently in Canada, Major General Sir David C. Bruce gave expression in his presidential address to the following: "Medicine in the future must change its strategy; instead of awaiting attack, it must assume the offensive!"

This statement not only marks clearly the distinction between the old and the modern conceptions of public health and trumpets a call to aggressive action in the field of prevention, but is also a note of confidence in the future part that preventive medicine must increasingly play in the field of community health.

Of the sciences, perhaps none has made such rapid progress in the past twenty years as medicine, and the fact that the most brilliant, useful, and enduring progress has been made in the field of preventive medicine is a matter of momentous interest to this and future generations. That "public health practice and activities have not kept pace with increased knowledge in preventive medicine" should not be a discouraging point, for progress in public health practice must always be conditioned upon the general community level of intelligent information of the facts of preventive medicine and personal and community hygiene. If, and when, there is widespread knowledge of the facts relating to personal and community health, practice may be expected to catch up with knowledge. Then human happiness and usefulness will be greatly increased and human life prolonged.

While not clearly stated at the time of inception, the survey of the eighty-six cities, made by the Division of Research of the American Child Health Association, on the suggestion of Mr. Hoover, our president, was, in effect, an effort to stimulate health activities so that health practices might at least make the attempt to catch up with public health knowledge.

Just what the gap now is between general public health knowledge and local practice in each of the cities has been quite clearly set out in the report of the surveyors. Data relating to the assets and liabilities of each city have been assembled and classified and when the report of the survey is published we will have a fairly accurate picture of what the cities of between forty and seventy thousand population are doing in public health and health education.

A prominent chamber of commerce man recently expressed his view

of relative values when he declared that the three most important things in which every community is vitally interested are: 1. a reduction of the tax rates; 2. a reduction of the freight rates; and 3. a reduction of the death rates. Assuredly this concrete expression of primary community interest is practically universal, and should challenge our attention and interest in that part of the program that relates to "reduction of death rates."

Effective health work, which must include health education, will very soon register its effectiveness in morbidity and mortality reduction from preventable causes, and what is equally important, will promote personal and community health, all of which bears directly and favorably on the community's economic problems and the general well-being and happiness of the individual citizen. It was with a no less ambitious program that the "follow-up work of the eighty-six cities" has been undertaken.

How may the findings of the survey be used to best advantage in promoting community health and in the reduction of death and morbidity rates? Before we can formulate an answer to this question, we must frankly discuss some of the problems that have arisen in an effort to evaluate and classify the information secured in the survey.

Sanitarians have, for many years, recognized that one of the most difficult problems is their inability to standardize public health practice on the one hand, or to evaluate results on the other. Every skillful and thoughtful worker in the field of public health has a nebulous personal idea as to what good public health practice includes and some notion as to its relative value, at least as the work is brought to bear upon his own community or State problems. Health demonstrations of various kinds have encountered the same problem, and have longed for some means or method for the measuring and evaluating of results. The survey of eighty-three cities by the Committee on Municipal Health Practice of the American Public Health Association and the survey of eighty-six cities by the American Child Health Association have only emphasized the necessity for some expression of group professional judgment in the form of standards for the evaluation of city health practices as they are related to the health project of the community as a whole, and also as they may be compared in different communities.

The operation of the old adage that "Necessity is the mother of invention," is plainly seen in the development, chiefly because of the problem presented by the two groups of survey cities, of a tentative rating sheet which it is believed will eventually help to bring into extensive use acceptable standards and values in health practices, and at the same time provide a definite health program for any community.

Moreover, such a rating sheet as is contemplated will not represent merely the combined judgment of the voluntary health organizations, but will represent the professional group judgment of practical full-time municipal health officers, devoting themselves entirely to official public health work. We will have, then, for definite use the pronouncement of group judgment of official agencies as to what constitutes a well-rounded health program, and the elements or items of that program stated in terms of relative values.

For the first time in the history of public health there have been assembled definite, comparable data from cities of over 100,000 population and from those of between 40,000 and 70,000, and there has been considered and prepared by a professional group of municipal health officers a tentative rating sheet for field trial in evaluating health activities. Thus we have, in effect, a provisional standard by which health officers may evaluate their own work by the measure of group judgment. Then too, we have a point of departure from which we can build for better health promotion and life protection which will not only make for prolonged life and less sickness, but which will tremendously improve the general welfare, happiness and economic stability of the people, for in its final analysis, wealth production must be largely conditioned on the physical health of the producers, and social contentment must rest primarily on economic prosperity.

The objectives in the "follow-up work of the eighty-six cities" may be stated as follows: first, to arrest the attention and arouse the interest of the survey cities in the findings of the survey by contact with commercial and social groups, and through them to promote interest in health by organizing citizens' committees or other special groups who will support and stimulate affirmative action by the municipal authorities in all practical undertakings for the advancement of community health; and second, to create a desire by the official State and municipal agencies for improved health conditions in their respective jurisdictions.

The approach to the first objective has been made in several States through their State departments of health and education, and in at least one of the States the second objective has been attained by the following means: first, by organizing the Michigan Conference of Full-time Municipal Health Officers, which meets quarterly with the State Department of Health for discussion and betterment of their mutual health problems, and who have requested an appraisal of their respective city health activities; and second, by the State Departments of Health and Education jointly promoting a county demonstration of health education in the public schools, and of teacher-training in health instruction in the State Normal School located in the county.

The importance and significance of these two movements in Michigan, which are the direct result of the survey of eighty-six cities, can hardly be over-estimated.

The approach to another State, in which a number of the survey cities are located, revealed the impracticability for that State of the Michigan plan. Therefore, upon the request of the State Commissioner of Health, there was placed at his disposal a man of ability as a community organizer who will attempt to assemble the community resources, as indicated in objective one, for the promotion and maintenance of an efficient, full-time municipal health personnel that will adequately meet the community health needs.

In another State progress in the development of full-time municipal departments awaits permissive legislation, and in yet another, the dust of political and professional prejudices awaits settlement before the avenue of approach to the question will be opened.

Sufficient progress has been made to leave little doubt but that each State or each city, as the case may be, must be considered in the light of the information at hand and the conditions found, as to the means and ways best suited to develop the community resources for health, always working with and through the duly constituted authorities in some agreed plan of action that gives reasonable promise of constructive results.

Within proper limitations, the resources of the American Child Health Association are at the disposal of State and municipal departments of health and education in carrying out this or any other approved program for the improvement of health conditions, especially child health, in any community.

Sir David C. Bruce was right when he said, "Medicine in the future must change its strategy, instead of awaiting attack, it must assume the offensive."

The Chair: I think we shall all agree that the outstanding features of Dr. Crumbine's paper are his statements as to the way in which health officers have agreed to rate themselves, and the working together of the State Boards of Health and of Education—that seems to me to be a masterly bit of strategy.

The next topic for this morning's program is to be the Report of the 1924 Health Education Conference, which as you know was held at the Massachusetts Institute of Technology, at Cambridge.

REPORT ON THE HEALTH EDUCATION CONFERENCE AT THE MASSACHUSETTS INSTITUTE OF TECHNOLOGY

C. E. TURNER, Professor of Biology and Public Health, Massachusetts Institute of Technology, Cambridge, Massachusetts

Are there any professional problems in your field which you would like to talk over with people who are doing similar work in other parts of America? I am sure that everyone of you could immediately suggest a half dozen topics which you would be most eager to discuss with other leaders. Every large convention is an illustration of this fact. There are two attractions which draw most of us to big scientific meetings. The first is the engaging possibility that we may get something of value from the formal papers which are presented and the second is the confident certainty of most valuable discussions with fellow scientists in the hotel lobby. Anyhow, if there is one in our number who has no problem to discuss, he probably will not rise to assert himself because he would thereby imply either that he has no new ideas or that he is so sure of his own superiority that it would be a waste of time for him to secure the reaction of other people. The conference at Technology was par excellence an opportunity to discuss problems.

In a new and rapidly developing field like Health Education the "working" or discussion conference is most valuable. Such was the Lake Mohonk Conference,—a new social instrument in developing a nation-wide activity. Such also was its successor, the Health Education Conference at the Massachusetts Institute of Technology.

By invitation there came together one hundred and sixty-one people who wished to discuss health education problems. They represented all of the groups of specialists who have to do with Health Education and they had selected in advance the particular topics which they desired that the Conference should consider. We came together as individuals discussing facts, not as representatives of either official or unofficial organizations for which we must secure publicity and whose ideas we must champion. There were no set speeches. Some individual was invited to open the discussion at each session but no one in advance had any pet ideas which they sought to put over and no direction was given to any discussion beyond trying to hold it to the topic in hand. No one knew what would come from the Conference and complete freedom of expression was given to every individual present, regardless of importance, title, rank, or position and with the same fairness which marks the most democratic and parliamentary assembly.

Eighty-nine of the one hundred and sixty-one people who attended the Conference came from the following fields of professional activity

as indicated: Public School Systems 27, Colleges 22, Health Departments 19, American Child Health Association 17, Normal Schools 4. The remaining 72 people represented 15 national, 11 local, and foreign organizations or agencies in Health and Education. Twenty-nine states and 2 foreign countries were represented.

By advance correspondence with members of the Conference it had been determined that the subjects which they wish to discuss could best be covered by providing one section on Teacher Training, and a second section on Health Education Administration. Section meetings were followed by general sessions at which a report was made from each section giving the consensus of opinion which had been developed there. The subjects were then open to general discussion. A committee, representing each professional group in attendance, was assigned the task of preparing a concise statement or summary of the conclusions of the Conference. Many of you have doubtless read this summary in the August issue of the Child Health Magazine as well as the comments upon the Conference which appeared in the July issue. It is not my purpose to review these findings but rather to indicate something of the value or significance of the Conference as a whole.

This type of public meeting can present most clearly a view of the "state of the art," its recent advances and its immediate problems. Its opportunity for the exchange of professional experience is of increasing value. The advance of the health education movement during the last two years was shown to have been rapid and general in most parts of the United States. At the same time the growth has been a sound and healthful one which has recognized that sound educational principles must be applied to health education programs. Such programs are more definite than at the time of the Lake Mohonk Conference. There is a clearer vision of what can be done and the specialists who must co-operate in any successful program have a better understanding of the contribution which each is to make. Happily this movement is developing with the best kind of cooperation and is remarkably free from professional antagonism. Cooperation in the field of Child Health is worthy of the great cause. There was indeed on the part of the special groups represented an expressed willingness to receive concrete suggestions and standards from the Conference.

The teacher training section brought out most clearly the fundamental importance of a well rounded health education program in teacher training centers. Moreover, these programs must vary according to the type of institution. The college, the four year normal school, the two year normal school and the special normal classes conducted for underprivileged teachers all have their distinctive problems and

their student health programs must be developed in accordance with the viewpoint of the students and with the time and faculty limitations. With some notable exceptions, it may be said that the great group of teacher training institutions still fails to recognize the urgent necessity for a student health program which is really functioning. The administrative head of such an institution must accept the fundamental responsibility for organizing this program and the whole faculty of the school must believe in it and support it, if it is to be a success. The physical educator, nutrition worker, or physician alone cannot develop a functioning program without the cooperation of the administrative head and the staff. We need a better technique for measuring student health but rapid improvements in the student health program are being made and will continue to be made because public opinion is rapidly reaching the conclusion that an institution which graduates students in poorer physical condition than when they entered is not worthy of continued community support.

In the field of Health Education Administration ample evidence appeared from many states that the Health Education Program is being improved in quality and organization. There is more definite agreement upon the objectives and activities for each age group and a more natural correlation of Health Education with all of the other school activities. Although some fine pieces of work are being done in the high school field, the Health Education Program for senior high school students perhaps needs development more than any other at the present time. Except in the way of physical activities much less has been done for these pupils than for any other age group. The problem is difficult but worthy of thoughtful and energetic study.

The rural schools present another serious need. We are rapidly becoming a country of cities and towns. Urban population is increasing; rural population relatively is decreasing. Yet as always life depends upon agriculture and the other basic industries. The development of our rural population is a question of such social significance that the city dweller as well as the agrarian should see that Health Education and education in general are carried to the rural school in the best possible manner.

We must see to it that in both town and city our program does not suffer from the dangerous temptation of a development which will be above the present limitations of the educational budget or the training and vision of the teaching staff. In the future as in the past, Health Education must develop as a natural and integral part of general education and of the whole school health program. The present centering of interests by educators upon the individual child rather than upon

the subjects to be taught makes this an opportune time for its expansion.

There is a growing appreciation of the difference between weighing and measuring as an educational device in interesting the child in health and in the use of weighing and measuring as a diagnostic procedure. This appreciation facilitates and furthers the usefulness of growth records in each of these distinctive fields. We need from the research laboratory still better standards for height and weight and further investigations into the relationship between growth, weight and normal health. We need a better standardized method for determining the health status of a school population and particularly a common method for recording physical defects so that the data from different communities will be comparable. Occasionally, data upon school health and particularly upon growth are collected inaccurately and used unwisely. The Conference, however, was perfectly clear in setting forth the rules which should be observed in collecting data and the statements which should be made when these data are presented to the people in order that a fair judgment may be made as to their accuracy.

Further study in Mental Hygiene and in the education of the runabout child appear full of promise. The effect of Health Education upon the temper of the child's thinking process and upon his attitude not only toward health but toward school and toward life should not be forgotten. The work which has already been done in the health training of the runabout child gives promise of great good to come out of these activities. I can hardly go farther here than to express the conviction of the Conference in the importance of these two subjects.

From its spirit of fairness, earnestness and toleration, from the vitality and freshness of the discussions, and from the verbal and written expressions of appreciation from those in attendance, it is certain that this Conference was most worthwhile and that it should be repeated in future years. I take the liberty of quoting from a letter received by this Association a few weeks after its close.

"I wish I might tell you how much I have been impressed with the conference. Personally I gained great inspiration, but quite beyond that the spirit of the whole thing was so wonderful. I have attended many Association meetings, never before has the Result desired been larger than the people desiring or presenting it. It's a great achievement in my humble opinion. I am most grateful for being included in an assembly which has such high ideals and so beautiful a spirit."

It seems reasonable to most of us that a group of experts like this is capable of making a real contribution to Health Education, but that is quite different from having the confidence that such a group could be held together without friction or professional antagonisms, to work

indefatigably and interminably, of their own volition and in interest of the cause of Child Health, through one of the hottest weeks of the summer; but this was done. To Miss Jean whose vision created this type of Conference and to Miss Dolfinger and her associates in the Health Education Division of this Association is due unusual credit, the thanks of those who were privileged to attend the Conference and I believe the thanks of all those engaged in the delightful task of Health Education. To me the Conference gave another thing which was, perhaps, as valuable as its stimulation and inspiration, namely, a renewed appreciation of the quality of mind and heart among the people who are serving the cause of Child Health and a new lesson in what can be accomplished by believing the best in people and expecting the most from them.

CONDITIONS IN THE FAR WEST

ELNORA THOMSON, R.N., Director Far Western Extension Office, American Child Health Association

The Far Western Extension Office will be a year old on the 15th of November. The activities of the Association in the West have of course covered a much longer period of time, for before the amalgamation of the American Child Hygiene Association and the Child Health Organization of America each of these had given service in special communities and in connection with educational institutions. In California the service given by the Child Health Organization has been continuous, and has become a part of the activity of the Far Western Extension Office of the present Association.

This year has been full of interest. The activities have been largely related to the various divisions of the Association, and as such have been reported by the divisions. In addition, however, there have been many contacts with individuals and groups who know the needs of their various communities.

We speak of the West as a whole, but it covers a vast area and presents problems that differ both in kind and in degree. The needs of the coast country are not always the needs of the mountain districts, the prairies, or the desert country, and the approach to the problem will differ even more than the need. There are fishing villages, mining communities, large cities, orchard country, and huge inland empire farming districts; big trees and sage brush, valleys below sea level, and the highest incorporated town in the world.

There are the pioneers of old American stock and the new immigrant—oriental as well as occidental. There are old problems, and such new problems as the itinerant child laborer and the congregation of the physically unfit, attracted by climatic conditions.

In the West will be found the lowest infant mortality rate in one district, and a pitifully high rate in another.

In many places very high grade work along child health lines is being done, and the workers in the various western states are fully alive to their needs, and many are seeking our help. The contest for the Far Western Child Health Demonstration has been keen, and many of the communities among those visited but not chosen will be asking for help of specific character, as some of the survey cities are already asking.

The West is new; its natural resources, human as well as material, are great. It has a consciousness of its needs.

It is our hope that the Far Western Extension Office may have an integral part in western groups, so that we may be able not only to

intelligently extend the services of our Association to the west, but shall also have brought to our councils the western ideas and ideals.

The Chair: As our conception of health changes from time to time, we find we go from one aspect of it to another. From the remedial we went on to the idea of prevention, and have become fairly familiar with that aspect now. But the very newest and latest thing, and one with which we are not all yet so familiar, is the promotion idea. The idea of the promotion of health is an interesting new phase of the subject in which we are all so much interested, and we are going to listen to a short report by Mrs. Aida de Acosta Root on the subject, which will be read by Miss Crandall. Nobody needs to have Miss Crandall introduced, of course!

Miss Ella Phillips Crandall, Associate General Executive, American Child Health Association:

Friends: Mrs. Root has asked me to present this report, or as it might be called, picture, for her.

Before reading it, may I take this occasion to say one or two words? You have apparently heard from about half of the staff this morning, because there are six professional divisions of the Association. But I would have you recognize that although not heard in all that has been said, doctors and nurses have been represented. Nobody in this audience, I know, needs to be told that doctors and nurses are as important in social work and school programs as the educator; or that our publication division serves us all, and we all serve the Publication Division. Looked at from this point of view, you may say that you have really heard from all of the division this morning. Miss Thomson represents all this in the far western states, and it is our wish, as Mr. Dinwiddie has suggested, to turn our faces westward, and give more service than heretofore to that part of the country.

It seems to some of us that there have been three major purposes in the plan of this Association: one to recognize the local community by encouraging community programs; hence, decentralization rather than the building up and strengthening of another national association. That is the first.

Second to work through and with the constituted authorities, to "lose our life" by merging it at any moment with other agencies who can carry the message in a larger or better way.

And third, while strengthening on every hand our professional workers, increasing their numbers by teacher training, and proper guidance, to go forth with a big, generous, and understanding appeal to

citizens everywhere to assume leadership in child health protection in America, letting the professional workers be their counsellors and servants.

This summary I think represents the professional aspects already discussed and also the appeal to the public, which Mrs. Root's report sets forth.

MAY DAY FOR CHILD HEALTH

AIDA de ACOSTA ROOT, Director of Promotion, Associate Director of Publications, American Child Health Association, New York City

The picture that is constantly being shown as to conditions in America is truly appalling. The people spend millions for candy, for chewing gum, for tobacco; they are more concerned with the health of animals than they are with the health of children; they are not willing to be taxed one mill on a dollar to give their children better educational facilities and health protection. People are not willing to have laws relative to health protection enforced. They are apathetic and indifferent to conditions that are terrifying when translated into the lives of children. They are fatalistic in their attitude towards the correction of physical defects. This is the indictment against "the people" in this great Republic.

But, "the people" answer, "See what we are doing. The Benevolent Order of Moose spends \$1,025.32 per child for the children cared for at their National Home at Mooseheart, Illinois. The million members of Rotary are supporting plans to see that the boys of today have a better chance. Many of their local clubs are spending time and money in an effort to see that crippled children are receiving proper corrective treatment. The Kiwanians have adopted a special program for underprivileged children, believing that they must have a chance if we are to have good citizens and not inmates of institutions. Other groups are organizing different programs for children of one kind or another.

"All of these are evidences of our tremendous interest, of our eagerness as individual citizens and as groups of practical men and women to see that the boys and girls of this country have a square deal."

Encouraging, we health workers say, as far as it goes, but can the American Child Health Association, building on this genuine life interest, find a way to build a bigger and more lasting foundation? Can it lay a foundation on which the child of today—the man or woman of tomorrow—may depend, not only for having his ailments corrected or for finding a home if need be, but that he may have the freest possible opportunity for growth and development?

If so, how? For many years now, professional groups of public officials have been working for these same people and their children, protecting, treating, teaching, and forever seeking and applying new knowledge. But they have in the main worked for the people rather than with them. Remember that we are speaking of the average citizen. Perhaps it is more true to say that they have carried the responsibility rather than put it squarely up to the people.

What, then, about the average mother and father? Does any one question that they care for their child? How, then, can they be aroused to their responsibility for their own and other children's health? Perhaps they have not been approached through familiar agents and in a language that they understand. Has any one realized the potential influence of the corner grocer in determining the kind of food that the mother buys? What about that of the clerk in the store who sells the mother clothing for her children? Has any one utilized and made effective these forces that touch most intimately the every-day lives of people?

It is possible to awaken the consciousness of the people in each home and community and the means of arousing them are already at hand. The fire is laid in each community and needs only that the match be applied. When once this fire of understanding has gotten under way, nothing can stop it. The people collectively will speak in one voice and their mandate will be heard in laws such as the Sheppard-Towner Act; but far more often and speedily in local ordinances and appropriations, and in appointments of qualified public officers and professional workers.

But the ancients found that a bundle of fagots has much more strength than a single twig. So we plead that all the forces that affect the lives of children be bound so firmly together that they cannot be severed.

These fagots or forces are made up not only of official, professional and scientific agencies but equally of the press, chambers of commerce, racial, civic, religious, social, patriotic and rural groups, industrial and commercial concerns, such as chain stores, milk companies, real estate firms, and many others, all of which have a vital, absorbing interest in our future citizens.

The American Child Health Association is an organization for organizations. It purposes to work largely through other agencies to the community and home and individual.

Carrying out this idea of reaching the people of the country through media that have intimate personal contact with them, the Bureau of Promotion has been developing a basis of cooperation with the retail dry goods stores, the chain grocers, Child's Restaurants, the labor groups, the National Congress of Parents and Teachers, Rotary International,

the foreign groups through the National Board of the Y. M. C. A. and the Foreign Language Information Service. Articles are being prepared for the house organs of the Amalgamated Clothing Workers, the Brotherhood of Locomotive Firemen and Enginemen and the American Federation of Labor; and special health material is being assembled for a calendar to be distributed to the employee members of the Amalgamated Clothing Workers.

Perhaps the most understanding piece of cooperation is the one worked out with Mr. G. P. Earnshaw, the publisher of a magazine edited for the buyers of infants' wear and the manufacturers of children's garments. Mr. Earnshaw has pledged the resources of his sales department to sell through all the important department stores of the country three million copies of the Mothercraft series, and has asked the American Child Health Association to furnish a monthly article on some phase of child health for his magazine which will appeal especially to the buyer and to the sales girl. He will arrange for nurses to hold child health demonstrations in the Infants' Departments of the retail dry goods stores during the first week of May.

Last spring, when the Bureau started out to arouse the people of the country to a larger consciousness of health for children, May Day was chosen as the occasion for an effective emphasis on child health because of the many picturesque traditions which surround and identify it as a day of joy and song for children.

The trail led all the way from the president of the United States to senators, representatives, governors, mayors, public health and education officials, doctors, nurses, teachers, institutions and social organizations, to the children themselves in hundreds of cities, towns and rural districts.

We asked nothing for the American Child Health Association—just that all groups and individuals should “focus the thought of the country on constructive measures for improving and safeguarding the health and welfare of the nation's children” on that day. The trail was long and the time was short—only eleven weeks—and the cooperation of the press was asked because no other agency had equal power to get quick action.

Would the press stand behind the movement to awaken the country to the needs of child health? They had done much to popularize the Sheppard-Towner Act and much in stimulating interest in the Better Baby movement. The response was almost overwhelming—editorial comment on the “May Day for Child Health” idea reached a circulation of 12,000,000. This does not mean news items. That circulation was impossible to calculate.

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The message they carried was not a joyous one. It began, "What chance has a child in our community to have a strong, clean, healthy body and mind? What are we doing and what can we do to remedy conditions?" Definite concrete suggestions were given, and communities from Maine to California organized programs that included pure water and milk supplies, well baby clinics, physical examination of the school and pre-school child, community cleanliness, rural sanitation, more physicians and school nurses and visiting nurses, more money for health work, public health councils and countless other items indicative of special local needs.

In many communities public health officers reported that May Day had opened doors which had been tightly closed to them. Quoting from one of them, "Now our hands will be upheld because we will have the confidence and cooperation of the individual citizen."

The Bureau of Promotion conceives its primary function to be to carry the truth about child health to parents as parents and to citizens as citizens, through every agency and in any form, within appropriate limits, that will get and hold their attention. It believes not only that they will receive the truth gladly—good teachers and doctors and public health officers and nurses—but that they, the people, will consciously shoulder the responsibility for child health in America, while all special workers and agencies will be their counsellors, guides and honored servants. The end of the trail is not in sight, but it has turned and already the people are asking for guidance. These requests the Bureau brings to the professional staff—for it is only through the labors of the entire staff and those of other organizations, that the end of the trail can be reached and the dark picture of ignorance and neglect be turned to the wall.

The program has broadened and deepened so that in 1925 May Day in many communities will but register the culmination of definitely improved all-year-round care of their children.

Let me quote from Collier's editorial on the 1924 May Day: "America first? Well, not in everything . . . all of which is by way of giving hearty endorsement to the designation of May Day as a day for auditing child health in every community in the United States. For our children we plan smoother paths than our feet have known; through them we can turn the gains of our generation into the victories of theirs."

DISCUSSION

Mr. Ewing: I would like to ask what assistance we are likely to have from the American Child Health Association in preparing for May Day, this coming year. Last year we received a little pamphlet that was very helpful.

Mrs. Root: This year we have what you are asking for, which will go out to everybody who asks. It will contain full information and a program. We hope it will help in the effort to have everybody join in this great movement, a movement that belongs to everybody.

The American Child Health Association has for its leader Mr. Hoover whose name carries a national and international emphasis in the great program. We are here, as Dr. Crumbine said, as an organization for organizations, and if we can go out and bring about an individual consciousness of the necessity of thinking in terms of health for the children of the country, and concentrate on this one day for the developing of that consciousness, we shall make it perfectly plain that the organization has something to give. I think the individuals of the country will begin to ask whether they too cannot get certain things, cannot do certain things. If the whole country could be aroused to this one thought, as Mr. Hoover said, every organization would be acting toward one end, and would help all organizations to get out technical material and help such as the American Child Health Association has to offer. It is a great deal to be able to give inspiration. And I believe that an organization that has Mr. Hoover, with his international experience of handling children in Europe, for leader will have a great opportunity to put this over.

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ENTIALS OF COMMUNITY ORGANIZA- TION FOR CHILD HEALTH WORK

Presiding, MISS ELNORA THOMSON, Western Representative of the American Child Health Association, San Francisco, California

Section 1. Some Methods of Health Supervision and Education for Mothers, Babies and Younger Children

I. Maternity Work.

GEORGE CLARK MOSHER, M.D., Chairman, Committee Maternal Welfare, American Association Obstetricians; President, Kansas City Obstetrical Society

II. Work for Babies and Younger Children.

1. City

a. Clinics or Conferences

MARY MARGARET ROCHE, Clinic for Infants, Grand Rapids, Michigan

Discussion:

MISS FALFREY, DR. SINCLAIR

b. Nursery Schools

LILA SKINNER, Nutrition Specialist, Merrill-Palmer School, Detroit, Michigan, and Michigan State President of American Home Economics Association

Discussion:

DR. RICHARDSON, Ames, Iowa; MR. EWING, Philadelphia; MISS SORTOR

2. County

a. Home Demonstration Agent

LOUISE STANLEY, Ph.D., Chief, Bureau of Home Economics, Department of Agriculture, Washington, D. C.

b. Health Department

FLORENCE L. McKAY, M.D., Director, Division of Maternity, Infancy and Child Hygiene, Department of Health, Albany, New York

Discussion:

MARGARET KOENIG, M.D.

3. Pre-school Study for Mothers

MRS. MARY H. WEEKS, Chairman, Children's Bureau, Kansas City, Missouri

MATERNITY WORK

GEORGE CLARK MOSHER, M.D., Chairman, Committee Maternal Welfare,
American Association of Obstetricians. President, Kansas City
Obstetrical Society

Motherhood, maternity, infancy, childhood—these are words which send a thrill through us as do no others in the language. The statement of Dr. J. H. Mason Knox last night that the initial harmony of the warring groups of the dozen types of nationals whom he was able to organize into harmony in Poland came through child welfare, strikingly emphasized this thought.

The relationship between maternity and infant welfare is so closely approximated that it is impossible to dissociate them. Hence, in the beginning of our Association for the Study and Prevention of Infant Mortality, a large number of obstetricians were included in the membership, and active on the program of the annual meetings.

Now, since we have become the American Child Health Association, there is nevertheless that feature to be included, because so much of post-natal infant mortality is to be traced to conditions directly connected with the process of birth. Also, the pre-natal disaster of the foetus, dependent on maternal toxæmia, or coexistent pathology of other type, jeopardizes the child as well as the mother.

We therefore continue to study the two problems, recognizing their close affinity, and the identity of methods of prevention, or cure, applied to them.

In 1922, Miss Grace Abbott, Chief of the Children's Bureau, in a paper in the *American Journal of Public Health* quoted Dr. Howard as saying that "the prevention and control of illness and death of mother and child are among the most neglected and potentially the most fruitful domains of public health administration."

Since our good friend, Dr. Adair, is today considering the question from the standpoint of early infancy, I shall confine my discussion to that of maternal welfare.

As a member of the first group who, at Baltimore, in 1909, crystallized into being the organization which has become such a powerful influence in welfare, and also having been one of the delegates named by the Governor of Missouri, to represent the State at the meeting in Detroit, in 1923, it is a matter of pleasure and pride, as well as an honor, to speak today, and to briefly note the accomplishment which has in the brief series of years been achieved in maternal welfare.

We have no way to improve conditions in the future but by judg-

ing of the past, and using that as a lesson. What does the past teach us in maternal welfare?

I am permitted to quote from the report of the Bureau of the Census, through the courtesy of Dr. William H. Davis, Chief Statistician, the statement that in a group of cities in the United States, having a population of 8000 or over, the death rate of mothers in child birth was in 1900, 14.9; in 1913 it was 17.2; and in 1916, 16.3, per 100,000 total population.

The latest obtainable figures on mortality are those of the late Dr. Otto R. Eichel, of the State Department of Health, New York, sent me in July, 1924, which show that in 1920 New York City had a maternal mortality of 5.1 per 100,000 live and still births; in 1923 it was 4.6.

In England, by contrast, the death rate from diseases caused by pregnancy and confinement had decreased from 13.8 per 100,000 in 1900 to 9.9 in 1914, and this remarkable improvement is coincident with the operation of the midwives act. In Birmingham the rate was 3.5 in 1916, 3.6 in 1920 and 3.5 in 1923.

The estimated maternal mortality of the United States for 1923 was 8.0 per 1000 births; sepsis accounted for 2.8 of this figure, according to Dr. Ralph W. Lobenstine, quoted in the *American Journal of Obstetrics*; certainly a melancholy repetition of statistics.

Now, why is it that while in Europe and Australia and New Zealand conditions have been gradually improving, in the United States, which should naturally stand at the pinnacle in maternal and infant welfare, no improvement is evidenced in over 20 years.

Several correspondents have been inclined to question the conclusions as to maternal morbidity and mortality being due to the obstetric care of the patients, but they rather ascribe them to incidental conditions, such as chronic cardiac disease, chronic nephritis, and tuberculosis. This is the strongest argument possible, as to the necessity of educational reform through every possible channel, patient, family, nurse, and physician, before these conditions can be improved.

Especially when we claim that eighty per cent of maternal mortality may, by prophylaxis and intelligence, be eliminated, the logical conclusion is to establish a system by means of which the relief is to be effected.

First, it must be borne in mind that pregnancy is not a physiological function, contrary to a long accepted theory of teachers who asserted that it was to be so considered. The demands of modern life upon the woman are such that she has reached the limit of her power to meet the strain of pregnancy, according to Sellheim in 1923.

He says that eclampsia and other toxæmias are a failure of metabolism to adapt the organism to the new situation, that of pregnancy, and he reaches the saddening conclusion that by culture, so far as it, at any rate, indicates a variation from nature, the whole process of reproduction has become a process which for the woman approaches the pathological. J. Whitridge Williams, also writing in 1923, estimates that 50 per cent of all pregnant women show some effects of toxæmia which he classifies as pathological. And Joseph B. De Lee, in the new edition of his text book on obstetrics, feels justified, while having in mind the inadequacy of statistics in general, in saying that in the United States 25,000 women annually lose their lives from the direct or indirect effect of pregnancy and labor. Of those who escape death, thousands of women flock to the hospitals for repair of injuries or the relief of diseases contracted during labor.

John F. Moran in 1915 asked for a nation-wide propaganda to teach the laity that the long cherished fallacy that pregnancy and labor are physiological, should be abandoned.

It cannot be too emphatically stressed then, that normal cases of labor are nowadays less frequent, as well as the fact that normal pregnancy is not the rule in our generation, regardless of what it may have been a century ago or among primitive nations of people whose women may have been endowed with less highly organized nervous mechanism than our wives and mothers.

The very fact that the woman of today is thus handicapped in her most sacred function, that of motherhood, is all the more reason for our throwing about her every form of protection.

Statistics from every prenatal center and all the clinics where careful records have been available, demonstrate beyond any shadow of doubt that there is a life-saving station which may be established in every community, which will go a long way toward eradicating both morbidity and mortality of child birth. We come directly to the one remedy—education.

The medical profession must itself take the lead in this propaganda for better obstetrics. It only requires energy and perseverance, intelligence, cooperation, honesty of purpose, harmony and disinterestedness and plenty of financial support to achieve its great purpose; and the Joint Committee on Maternal Welfare is a long step in the right direction.

This committee was formed last year, comprising representatives of the Child Health Association, the American Gynecological Society and the American Association of Obstetricians, Gynecologists and Abdominal Surgeons. Through the generosity of the parent associations

the committee has made a start in the only effectual method of bettering maternal and infant welfare.

In order to start the movement for a concerted action, it was decided to find the attitude of the individual members of our joint committee so that we should be given a formula upon which to build a framework covering the phases of causes of maternal morbidity and mortality. Before determining upon the program to be worked out in cooperation with State Medical and County Medical Societies and the State Boards of Health, we made the inquiry in the form of a questionnaire. We forwarded this to the members of the joint committee.

The very emphatic answer came back almost as if by one voice.

It was as follows:

1. That the medical profession must recognize the fact that it is not itself flawless. The causes on the part of the profession of maternal morbidity and mortality are:

(a) Insufficient teaching of medical students in the colleges.

(b) Inadequate preparation of students in medicine; generally their own fault, forgetting all didactic instruction as soon as they graduate.

(c) Failure of physicians in charge of maternity cases to apply their knowledge to the work in hand.

2. On the part of the laity, the contributing causes were given as:

(a) The hopeless ignorance of women in the simplest truths of life.

(b) Abortion, criminal or preventable—women have confessed to 12 and 15 inductions without a blush. A world-wide education without mincing words is demanded in this.

(c) Neglect of early consultation with medical men.

(d) Listening to old mammy's superstitions and following advice by faddists and cultists, regarding child birth; usually harmful or disastrous.

(e) Indiscretion regarding exercise, diet, indulgence in questionable pleasures, fast living, drinking, smoking and other pastimes.

(f) Ignoring diseases which, if taken in time, might have been cured or corrected.

Dr. W. S. Rankin, Health Officer of North Carolina, says that 750,000 or $\frac{1}{3}$ of all the $2\frac{1}{2}$ million births annually in this country, are attended by midwives or are given no assistance in their travail with no ray of medical science to dispel the gloom of ignorance which overshadows them.

No prenatal care is received by a million and a half other mothers, so that five times as many prospective mothers are neglected as those who have supervision during their pregnancy.

Midwives, Dr. Rankin says, are not universal nor uniformly distributed. The barbarism of midwife conduct of labor is an anachronism; it is one of the causes which places us seventh from the top of the list of seventeen so-called civilized nations in infant welfare, and fourteenth from the top in maternal welfare—our maternal death rate being exceeded only by that of Spain and Belgium.

This makes us a disgrace among the countries of the world.

The increasing scarcity of doctors in the rural districts, especially in the sparsely settled sections like the mountain regions of the South, makes the midwife a necessity and her elimination a matter for future solution. Hence, it is difficult to furnish a substitute for this traditional unskilled obstetric service, because there is no one else to call on.

Dr. Rankin further says the status of the midwife is a state of mind, which can only be changed by education of the entire rural population; education of the doctor to his obligation of leadership in the relation to the present great wastage of human life, due to lack of modern scientific methods; education of the community to municipal responsibility for the physical integrity of its citizens, especially along lines of sanitation and law enforcement; education of parents in the fundamentals of hygienic living, and obligations to their children; and education of the nurse and even of the despised midwife, so long as she must be tolerated to play so important a part in rural community life.

If we subscribe to all this melancholy category, what are we going to do to correct it?

A brief outline of the accomplishment of the joint committee of the three Associations in the endeavor to arouse the medical profession to a realization of its responsibility may be of interest. We have mailed to the Secretary of each State Medical Society an appeal for more obstetric papers and more discussions on obstetric subjects in their annual meetings. We have also obtained through these officials the cooperation of the Secretaries of the County Society units under their jurisdiction in a similar service. Not quite so extensive a poll as that of the *Literary Digest* in the campaign for President, but a huge undertaking for a small committee with very limited means.

It is remarkable how prompt the replies are, coming back from both the State and County Secretaries, evincing their interest. Many of the County Secretaries have not yet been reached, but invitations for the welfare talks are coming in faster than we can accept them. This attitude is most promising.

We have taken up with the Maternity and Infant Welfare Divisions of State Boards of Health the questions in which they can be officially interested. More accurate registration of births; prenatal and maternity

clinics; talks to mothers and prospective mothers; and suggesting the boards of regional obstetrical consultants which have been such a successful adjunct, especially in Ohio and New York. Missouri is just now developing such a corps of regional consultants, carefully selected as representing the various sections of the state, and these will aid Dr. Irl Brown Krause, the Director, as he finds he can use their services.

Letters of similar import have been sent to each of the medical journals urging that more space be given in their columns to propaganda in behalf of maternal and child welfare.

So far the work of our Committee has been largely confined to propaganda among the medical profession, in behalf of better obstetrics—especially in the matter of prenatal care—by the educational methods just mentioned.

A great educational force among the laity was instituted in the creation of the Sheppard-Towner Act of Congress. In reference to the administration of the Sheppard-Towner law, the attitude of the medical profession in some instances is analogous to that of certain clergymen regarding the Defense Day observance on the part of the nation. This opposition is confined to a small minority, and is due entirely to misapprehension.

Nobody wants war. We all hate war, but the world has not yet reached the state of Utopia which some college professors and ministers seem to dream it has, where anybody can afford to go to sleep and not bolt his doors.

Hence, a state of preparation, of preparedness, is the best means of preserving the peace of the world.

Quite similar is the situation in reference to the Children's Bureau and the Sheppard-Towner bill.

We admit that maternal mortality has not yet been reduced in the last third of a century. We discuss the facts and we do nothing actively or energetically to remedy the situation.

The women of the nation take up a campaign of active propaganda and behold, a law is passed, which has certainly accomplished results in individual localities which will serve to leaven the whole if we but give it our hearty cooperation.

What is the intention of the Sheppard-Towner law? It is that an opportunity shall be given to women to appreciate what is good prenatal and obstetric care, and then to attempt to make available adequate community resources, so that women may have the type of care which they need and should have for the asking. This is the answer given by Miss Abbott in 1923.

These plans must always originate in the state; and in letter and spirit it is claimed they do so adapt themselves to meet the local needs. Through the Division of Maternity and Child Hygiene of the State Board of Health, efforts are directed to secure in a county the demand for clinics. These must, in the majority of the states, be through the County Medical Society and the local profession is to furnish the talent which combined with that of the Director of Welfare is to be utilized.

The program to be adopted in any State should be one that is based on the needs of that State, as to what skill is available and easily obtained by women in different parts of the State. The fact that many prospective mothers do not start with the premise that they know what is good prenatal care or good obstetric care, makes it necessary that some program must be undertaken in certain regions to build up a structure, not perhaps ideal, but of minimum requirements, which they will themselves demand.

In Ohio this has been very thoroughly done and the results more than meet the expectations of the most sanguine.

The July, 1924, issue of the *American Child Health Magazine* has a very interesting story of the growth of the Health Center plan in Mansfield and Richland County, Ohio. This work, begun as an experiment, financed by the American Red Cross, has grown to such an extent that the director, Walter H. Brown, M.D., is now employed by both the City of Mansfield and the County, through a consolidation of the official agencies.

Physicians of the county have of their own accord and in cooperation with the Director formed post-graduate courses for further study in obstetrics and pediatrics. All nursing in the city has been consolidated with increasing community financial support. Encouraging progress has been made toward a thorough plan of health work by the school authorities in both city and county. It has been the means of showing to the community the actual working out of many of the elements of a practical program of maternity and child health work, including the fundamental features of prenatal care; obstetric care; health supervision of babies, and pre-school children, as well as a well-rounded program of school health. As the magazine says, "it has made a marked impression on the community mind and conscience."

This is the sort of demonstration which can only be consummated when the various elements concerned combine to work in harmony for the results to be accomplished, and include the public, the nurse, the prospective mother, as well as the mother and the medical profession.

The September number of the *Ohio State Medical Journal* states that in 22 counties in Ohio there are 43 prenatal, 36 maternity, and 45

infant welfare clinics, all conducted under auspices of the local boards of health and private agencies.

Missouri has not been included in the Birth Registration Area, consequently the records of our births are so far from being accurate that they are practically worthless. The State Board of Health and the Bureau of Hygiene have made most strenuous efforts to correct this unhappy situation which has exposed our fair state to much unjust criticism and invidious comparison with the other states. I am informed by Dr. S. J. Crumbine today that an investigation of the Child Health Association reveals the fact that checking infant deaths against reported births shows that 25 per cent of the births in Kansas City are not reported. If these missing figures were added, Kansas City would stand 68 instead of 92.

It is a matter of common knowledge that in many communities not half the births are being reported. All infant deaths and maternal deaths are bound to be reported. Hence, we suffer in the eyes of the world as being among the worst offenders in mortality on this account.

A glance at the graphic chart sent out in August by the *American Child Health Magazine*, showing the death rate of over 600 cities, is of absorbing interest, and will speak for itself, emphasizing the benefit of the health center idea and accurate statistics. It must be recognized that for Carthage, Missouri, to have an infant mortality of 26, while St. Louis has 72 and Kansas City 92, there is only the explanation that statistics to be of value must be analyzed in large groups rather than by reports from the smaller communities.

In our own state and city it is believed that with the work of the State Board and the Director of Hygiene which is now being aided by a competent statistician from the Child Health Association; and with the praiseworthy efforts of the Children's Bureau of Kansas City, a pioneer group under the leadership of Mrs. E. H. Weeks, one of our most brilliant citizens; with the Bureau of Regional Consultants in Obstetrics, and also the Maternity Center which Kansas City has recently established, all these conditions will be corrected, because we shall have the cooperation of these workers, all striving to effect the much-needed reforms.

The conduct of model obstetric centers giving ideal care to poor and rich alike will go a long way to improve conditions. The Committee desires to help the physicians of all the states to appreciate the benefits and possibilities of the Sheppard-Towner Act, and assist in establishing obstetrical centers in the various communities throughout the country, as object lessons, until the local authorities see the light,

and are willing to continue the work at their own expense, as a high class investment, that is in health and happiness.

Of course, it is not necessary to say before this body that what the Joint Committee on Maternal Welfare has in contemplation is in the nature of a popular revolution of ideas. Our program is, therefore, subject to difficulties proportionate to its scope and vision. Many minds must be reached and convinced. Time and persistence are needed to effect these widespread and iconoclastic results.

Many of the statements included in this report have been duplicated until they seem trite. But they must be repeated and again duplicated oftener and increasingly.

In propaganda and education the committee puts its faith. We cannot afford to tire of the subject because it has been discussed before. The work and the effort will be justified.

WORK FOR BABIES AND YOUNGER CHILDREN

Clinics or Conferences

MARY MARGARET ROCHE, B.N., Clinic for Infants, Grand Rapids, Michigan

Not long ago I attended a luncheon for social workers—there were long tables surrounded by us and visualizing myself as the not impossible victim of misfortune my heart sank at the thought of so much interest—as there represented—to be taken in my “case.” We wonder at our own temerity at feeling so capable of advising in each and every capacity any trouble-tried individual that applies for aid. It makes one wonder if one’s own success in making—not only in living—a life has been great enough to warrant the presumption. Interest in public health has advanced with such leaps and bounds that it is difficult to keep one’s zeal within the bounds of moderation.

These thoughts force themselves upon those of us connected with welfare work. When we see a room crowded with eager mothers who have brought their little children to be helped and healed we are grateful for the faith that has made the coming possible. It is the ideal of each of us to do everything in our power—through these clinics—to preserve and lengthen life and to make it happier in the living, to imbue the mother with the desire to live correctly and happily, and to secure for her children that most valuable of all birthrights—health.

It is axiomatic—protect the unsound in mind and body from perpetuation, carefully lay the foundations of health, cultivate health habits for the three dimensions—soul, mind, body—and you achieve the fourth dimension—the harmonizing of all three into something approaching perfection of living. To do this well means to abolish disease, crime, poverty and all their attendant evils and make obsolete the words feeble-minded and venereal disease. Utopia, of course, but who would be content with a lesser goal?

Our clinics may be wholly supported by voluntary contribution, wholly under the control of municipal or city government or, as some of us believe to be the best plan, be the joint responsibility of the public and private agency. Certain ideas of conduct and management are equally applicable to them all. The surroundings must suggest cleanliness and simplicity; they must not by their elaborateness and impossibility of achievement by the individual encourage in him the idea that these two columns of the temple of health must have as their base abundant means. For that reason marble halls and tessellated floors do not make the proper appeal in a clinic for the people.

There must be conservation of time of everyone concerned: the

little patient and his mother, the physician, the nurse, the volunteer, and yet every detail of the business involved must be consummated with such skill that while time is so conserved the accurate history of the patient and his general condition are carefully noted, the doctor's orders exactly recorded, the mother satisfied that her child's condition is understood, that the advice given her is such that she can proceed at once to act upon it intelligently, that her presence there is most welcome and that she is expected to come again. To accomplish this is not an easy matter when the shrieks of tired infants with deranged digestion rend the air tending to incite to emulation those whose little systems are more correctly regulated. Always overhead expenses as well as capital involved must be considered in arranging satisfactory quarters. With the rapid growth of our cities, overcrowding is difficult to avoid. The careful placing of equipment not only gives the appearance of space but accelerates the work of the day.

In baby clinics we have found that assigning certain duties makes smooth running more possible, one person to receive the mothers, hand them the clean blanket while explaining the routine to be followed, one to take the social and medical history, one to weigh, one to chart this weight and another to send, in their proper order, the patients to the physician where the nurse in attendance takes notes of what transpires there. The clerk who answers the telephone sees to any purchases that are made. Of course, clinics can and are operated with fewer in attendance on the wants of the patients, but our most successful days are when our volunteers report as scheduled and the above routine is carried out. The difference in the condition of the babies, their mothers and in fact all concerned after a clinic where every post has been filled is quite different from that when few have attended to their duties and fifty or sixty crying babies and their nervous mothers have struggled through a long afternoon of waiting. Where space permits, it will be found helpful to have a preschool play room where the little child coming to the clinic with mother and baby sister may find under the care of another volunteer that there are wonderful times to be had. In a city of any size, with the opportunities now open to women of acquiring the newer point of view that the walls of the home where charity beginneth are not the circumscribed ones of their own dwellings, provided that the nurses themselves are willing to permit these services on the part of lay persons, one should have no difficulty in making attractive this service that they can render.

With the preschool children we tried the class method of instruction of the mothers of the undernourished similar to that suggested for the school child. This we have abandoned in favor of individual instruc-

tion of each mother as we do in the case of the mother of the baby. We were fortunate enough to secure the assistance of a trained dietitian who volunteered to give classes in food preparation to the mothers of the persistently underweight. The mothers prepared spinach, asparagus, carrots and the other unappreciated articles in the child's diet while the children were entertained in the preschool play room. The products of their labors were served to the little underweights for their midafternoon lunch, and to the surprise of the mothers and the delight of the founders of the movement the food was eaten with relish. Two points were gained: the mothers learned that if food is prepared properly and served daintily the child will be interested in it; the child learned that green vegetables were not meant to be resisted and that their first impressions were not always to be relied upon.

We admit to our clinics any baby or child under school age for advice as to general care and proper feeding without regard to the social or financial standing of the parents. They are as democratic as the public schools and are regarded as filling the need for education in this line as the public schools do in theirs. The sick child is referred to his family doctor when the family can make satisfactory financial arrangements. A confidential social history is sent to him by us. When unable to pay for the care of the child we make arrangements for it through hospitals or other physicians as the case warrants. By this method we not only stimulate interest in keeping the baby well and insure recognition of the fact that the sick baby needs his doctor at once but strengthen the tie between the family and the family physician.

But no clinic can be successfully conducted and the wished-for results obtained without adequate follow-up work. The home must be visited and the mother shown how to carry out the orders that she has received from the physician or the task falls short of accomplishment. Here the tact and the teaching ability of the nurse as well as her skill in nursing sick babies are taxed to the utmost.

In 1920 our Chief of Staff brought back from the St. Louis meeting of the now American Child Health Association the Minneapolis Plan and in connection with our clinic work we began the regular monthly visit of all babies born in the city. This not only increased the amount of extracted breast milk that we collected, but it brought earlier to our attention sick and premature babies who needed it and, so we believe, it has accomplished a very great reduction in the infant mortality rate of the children surviving the first week of life. If infant welfare work were ideal, one hundred per cent of the babies born would be fit to live, but unfortunately this is not the case. Scientific knowledge and health education facilities are approaching the point where the

babies born should have every chance to live. The further improvement must come in the prenatal period and even before that precarious first week of life.

To summarize the matter—the success of any clinic is dependent upon the cordial understanding and good feeling that exists among those who support, those who operate and those who attend it. It attains its widest usefulness when its object is not to glorify and advertise any particular sect or organization but represents the united effort of the community to serve the community.

DISCUSSION

The Chair: I am sure this is a most interesting report and deserves discussion. I should be very glad to hear from some one on the subject who has had some experience in regard to these conferences.

Miss Falfrey: I should like to know how these volunteers are organized. What inducements are held out to them to come regularly?

Miss Roche: The volunteers who assist in the pre-natal clinics are members of an organization known as "The Little Folks Welfare Society." They supply layettes for the needy mothers. They serve cocoa in the nutrition clinics. Those are the only clinics in which we serve any food. Our reason for doing this is that if we take the children away from the home at the time they are supposed to be having nourishment we point the lesson a little more clearly if we give them cocoa when they are with us at their lunch time.

Those volunteers are absolutely regular except during the summer months and we don't expect any volunteer to be regular during the summer months. Just now we are having organized in Grand Rapids a branch of the Junior League and a great many of our volunteers will now give service through the Junior League, which amounts to three hours per week.

JOHN F. SINCLAIR, M.D., Babies' Hospital of Philadelphia: I should like to ask whether they deal in Grand Rapids with the family as a unit in these cases. Our experience in Philadelphia has taught us that to do effective preventive work, we must deal with the family as a unit. To see the individual child or children in the clinic is not enough; the whole family must be investigated by the field worker, and that family taken on and carried through a period of years, if we are to be able to do what should be done in the preventive way for the children of that family.

Miss Roche: I think no one of us could consider the child as an individual apart from his family because to do that you would be taking him out of his environment. In taking our clinic history we always take the history of the entire family. We know the father's income and if we have to refer to that family for relief of any kind we always verify this income. When we make our visits if there is any other member of the family suffering from any physical or mental defect that case is always reported to the proper agency. We wouldn't feel we would be doing our very best for those babies or little children unless the rest of the family were being cared for as adequately. We make monthly visits to every baby that is less than a year of age whether they come to the clinic or not. Now that has stimulated the mother to send sick babies to their physicians.

NURSERY SCHOOLS

LILA SKINNER, Nutrition Specialist, Merrill-Palmer School, Detroit, Michigan,
and Michigan State President of American Home Economics Association

I have been asked to discuss methods of health supervision from the standpoint of the Nursery School.

In using the word health we ordinarily think of it as simply meaning physical fitness, but we know it goes much further than that and that it must include not only physical fitness but mental fitness, social fitness and moral fitness as well. It is from this standpoint that the health education is planned in the Nursery School of the Merrill-Palmer School in Detroit. We try there to help the child form proper physical, mental and social habits and to educate him not only for completeness of mind and completeness of body but also for completeness of character. We try also to give the mothers and young women whom we have with us a better insight into child capacities and characteristics, teaching them to care for and to manage the children intelligently and wisely.

We have developed the work along three different lines: the work for the children or preschool; the work with the students or pre-parental; and the work with parents or parental.

We consider the child of first importance because it is here that we have the foundation for our work and we can also use the child as a demonstration for the other two groups, but we must remember that in making use of the child we must provide conditions as nearly ideal as possible from every standpoint, not only from the physical standpoint but from the mental standpoint and from the social standpoint.

In regard to the equipment used in the Nursery School, everything is planned for the child, and that equipment has been selected which will administer to the physical and mental development of the child. Everything is made for the children themselves, their lockers their own size, their wash bowls, their mirrors are such that they can see into them, their chairs, their tables, and so forth. We teach the children to take care of themselves physically, realizing that this is a very important element of education.

As to the educational equipment, we have tried to provide the children with every type of activity which seemed wholesome and suitable to their ages. The children are from two to five years of age.

Indoors they have their blocks of various sizes; they have their clay for modeling, their drawing materials, their paints, chalk, picture puzzles, toys, scissors and all the Montessori apparatus. We also have

a work shop where toys are made at the school for the children and some of the older children help in the construction of the toys. By the older children we mean those of from four to five years of age.

Out of doors we have boxes of different sizes for climbing and jumping, planks for walking up and down, teaching the children balance, and we have other standard equipment such as sand piles, shovels, kiddie cars, and this equipment is constantly being added to.

The children come to us from an unselected group and so represent the community at large. The only requirement that we make is that the children must be normal children.

The children come to us at nine o'clock. After removing and hanging up their garments, they are inspected by a nurse who is furnished by the Detroit Board of Health. Then the child goes into the school room and on the way is given a drink of water. The first hour in the school room is spent in work. Each child chooses its own occupation, and a definite effort is made to see that the child carries some piece of work to completion before going on with another. The children are taught to put each thing in its place before getting out other material with which to carry on another piece of work.

When they leave their work they gather in a circle and some of the children tell stories, or sing songs, or play games. That takes about fifteen minutes. After that time they are given their mid-morning lunch which consists of fruit juice and cod liver oil and water.

They then go out of doors to play and here again each child chooses its own occupation. If they ask for help it is given to them, but we try to have them carry out for themselves anything that they may start.

When they come in they are taught that they must wash their hands and faces and comb their hair. Instruction in rhythm, responsive music, singing, dramatization of songs follows, and this music time is very popular. No child is compelled to join in this unless he wishes, but we find very few children, even among the youngest, that are not very much interested in this music period.

After this they go upstairs to their sleeping rooms for a very brief period of relaxation. The older children soon come down and set the tables, and then all the children come down for dinner.

All of the serving and all of the changing of plates is done by the children themselves. Here we carry on our educative work in the formation of proper food habits. The children create a social atmosphere which is such that it becomes a virtue to eat and very shortly, within two or three days, the child is sending back a clean plate and often asking for a second helping. So the problem is solved by the child himself.

After dinner the children go to the toilet and wash their hands and go upstairs to sleep for two hours. The ventilation, of course, is carefully watched, not only during this period but throughout the day. After their naps they come downstairs for a small glass of milk and then go out of doors to play until their parents come for them, or the bus takes them to their homes.

No child is admitted to the school without a complete physical examination which includes the usual routine examination and laboratory tests. Monthly studies are made of the children from the standpoint of weight and height—height being taken in both the recumbent and standing positions. Records are made of the stem length of each child and of the head and chest circumference. The posture of the child is noted, diagnosis made and, where necessary, corrective exercises are given. An instructor comes to the school twice a week to give these exercises, the mother being present for one or two lessons in order that she can carry on the work at home.

The mental development of the child is measured by the standard tests.

Briefly, some of the results that have been attained are: A great gain in the physical condition of the children; practically all cases of constipation have been overcome; there was albumen in the urine of several children when they first came to us and this very shortly cleared up. We found a great increase in the blood count of many children after they had been in the school for a short time. There has been a startling gain in the intelligence quotients of the children. But perhaps the most striking result is the improvement in the social relation and the type of reaction toward other personalities. This, however, is more difficult to measure than the gain along the physical and mental lines.

As to the pre-parental training, the interest of the college and university groups is evidenced by the cooperation of fifteen of the leading schools in the country who have sent students to us. The home economics student comes with a better background for undertaking our work and a better understanding generally of the various home problems.

The courses offered to these students deal with child nutrition, child psychology, child management and social service. The laboratory work consists in allowing the student to help with all the practical problems of the school. She helps the physician when he makes the physical examination; she is present when the laboratory tests are made and the findings for each child are discussed with her. She studies the dietary needs of each child and, under supervision, she plans the diet that will fit the requirements of the child, insofar as we are able to judge, in the

light of our present knowledge of nutrition. She keeps food intake records, studies the home diet and makes a very complete study not only from the standpoint of the amount of nutriment necessary, but also a study of the type of food which the mother is giving the child, and because of this study she is able to make many valuable suggestions to the mother. Each student has some practice in the method of preparation of food for the children. She keeps records of the physical measurements from month to month, makes graphs showing the rate of growth in comparison with various standards. She learns the method of mental testing and she sees some of these administered. She observes the occupations and behavior of the child from day to day. She makes a personality study of three or four children who interest her most and she makes a complete physical history of one child who has been in the school for at least the period of one year. Her class work includes a series of lectures on fetal development, mechanics of labor and care necessary during this period. These lectures are given by a professor of obstetrics from the Detroit Medical School.

A student who has had this preliminary work will be better prepared for the task of motherhood than the average mother of today.

As to the parental training, one essential requirement for admission to the Nursery School is the cooperation of the mother in every way. A nursery school that is not cooperating with the home is socially not sound. It must not take the place of the home and it must not assume the responsibility of the home. It must not be a place where the mother can simply park her child. The Merrill-Palmer School works with the parents and shows them where and how they can better develop their children in every way, acting as a guide. Mothers are called in for individual conferences in relation to character problems that come up regarding the children and also in relation to any physical problems. The results of the physical examination and laboratory findings are gone over with the parents. The menus are sent home a week in advance so that the mother knows exactly what the child is having to eat at the school. Breakfast and supper suggestions to go with the dinner at the school are also sent to the mothers. The mother keeps a record of the food eaten by the child while at home at certain periods during the school year. The mother also reports the time the child goes to bed at night and the time the child gets up in the morning. She also keeps a daily bowel report. If corrective exercises are prescribed she comes to the school and learns how to give these exercises. The difficulties are explained to her and the reasons for early treatment. She then sends in a daily report on the way the child is taking his exercises. The mother is encouraged to visit the school and to ask for conferences.

Not only is the mother encouraged to come to the school but the father as well. Some of our work has been undone by the father's attitude and due to his lack of understanding, and sometimes to his unconscious selfishness. I do not believe that we will get the results that we want and that we should get, until both parents realize the importance of proper habit formation, not only from the physical standpoint but from the mental and social standpoint as well, and until they both, with this understanding, work together for the child and with the child.

DISCUSSION

The Chair: Doctor Richardson, we should be glad to hear from you.

Dr. Richardson, Ames, Iowa: In our State College we have what we call our Child Laboratory, in connection with the lecture course in child care and training.

Our Senior college women have a chance there to do much the same work as Miss Skinner has outlined. Our children, instead of staying for the entire day, stay from nine until eleven in the morning. The main thing we are attempting to do is to give the college women some management of the children as well as an understanding of the feeding problem.

In the short time we have been at work it has been well demonstrated that it is a perfectly practicable problem to introduce into a State College. It is not too expensive, and the people can be found to handle it, and the Seniors of the College will react to it.

Mr. Ewing, Philadelphia Child Health Society: Mr. Chairman, I have something I very much want to say from our little experience and while it is not strictly nursery school I want to talk on but what, from our experience in University Extension, we might call Nursery School Extension.

I think all social workers, doctors and nurses and all educational workers will agree that our greatest difficulty in educating children and correcting the defects of children is that the parents do not know how to carry out the recommendations of physicians and nurses and educators. I think that is the general complaint. A little while ago, a physician, who is one of the Directors of the American Child Health Association, said to me that it is the bugaboo of the medical profession. I quoted him to the professor of a school and he said, "You may tell him that is the bugaboo of the educational profession." And I have talked to the nurses and they feel the same.

A short time ago in one of our pre-school examinations, a doctor examined a child who had a second set of teeth coming in before the first teeth were removed. A perfectly simple matter for the doctor to tell the mother, "You must go to the dentist and have those teeth extracted." The mother didn't go and the case was followed up by the nurse and the latest report we have is the mother says, "I can't take the child because the child doesn't want to go to the dentist."

Time after time we find in our pre-school work the trouble is that the child runs the family instead of the parents running the child. Honestly, I think a large proportion of the adults in this country have no business to have children at all, they are absolutely unfitted.

Now, I think somehow or other we have got to carry training to the parents as

to how to train the children, how to control the situation. The ideal is the Merrill-Palmer method. We must get to the parents we are now dealing with, a solution of this problem of how to correct the defects of the children, which means how to manage a family. I feel very strongly that we can't wait for the education of the next generation.

In Philadelphia, the Child Health Society's work has resulted in the introduction into the school curriculum of training in the care of children for our seventh and eighth grade girls. Now that is a help but, of course, it doesn't go far enough. It doesn't teach them the psychology of the child, nor an understanding of his motives.

I think we ought to plan to get some one who is well qualified to lead and guide the parent, to go into the home. What we really need is a psychiatric social worker in the cities. The question is whether we can get a psychiatric social worker, something like the school visitor who is coming to be used with school children that have behavior problems in the family. We need the same type of visitor for behavior problems with pre-school children. And there you come to the question of getting another person into the family, and it is always a poor thing to introduce too many into the home. Can the nurse with all the training she now has to have superimpose on that what would probably be pretty nearly a year's extra training in psychology and all that goes with that in order to fit her to do this? As it is, I think another person will have to be introduced by the nurse so as not to make too many contacts in the home. I am sure we have got to put our minds to that problem and teach parents how to train their children and how to control the family situation.

Miss Sortor: For the last fifteen years I have been attending conferences and that same question has come up year after year,—How are we going to do it? Last week I was asked to go before a colored charity for the Charity Committee and there I found them, I believe, getting nearer to the problem, how to do it, than any other association I have ever heard of. The colored workers from the Community House are going into a neighborhood, a block at a time, and holding neighborhood meetings. One evening they held a meeting in a basement hall and only five attended. They held another in the same hall last week and there were nine in attendance. They are taking in a trained nurse with them.

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THE CONTRIBUTION OF THE HOME DEMONSTRATION AGENT TO HEALTH SUPERVISION AND EDUCATION FOR MOTHERS, BABIES, AND YOUNGER CHILDREN IN RURAL COMMUNITIES

**LOUISE STANLEY, Ph.D., Chief, Bureau of Home Economics, United States
Department of Agriculture, Washington, D. C.**

That the home demonstration agent has a contribution to make to health education is indicated by the inclusion of this topic on the program of this meeting. A brief statement of her duties and the organization of her work has been prepared in order to show the contribution she can make best.

The function of the home demonstration agent is to carry to the rural woman information that will help in her homemaking problems. The agent goes into the country and meets the women in their own homes or in small groups and demonstrates to them the best home practices. While you cannot look upon work which influences the home as benefiting any particular age group, certainly the mothers and pre-school children are more directly touched by such a worker than those members of the family who may spend fewer hours there. In the past, emphasis has been placed, perhaps, on practices that may seem in some cases to be quite separated from health. This can be accounted for by the need of supplying definite solutions of problems and the desirability, as in any new piece of work, of "getting easily measurable results," but most of these practices have meant also improved home conditions and have paved the way directly or indirectly for better family health. Food work in the early days of home demonstration may have seemed to be entirely "cooking and canning," but now these are taking their rightful place as parts in a larger nutrition program, and the dress form and millinery projects are rapidly taking place in a broader clothing program planned on a basis of economics, design, and hygiene.

The county home demonstration agent is appointed by the state extension director, her choice being approved by the Washington office and the county advisory committee. She is paid through a combination of Federal, State, and county funds. Her work is guided by a county advisory committee and is approved by the State office.

The State specialists in the different phases of home economics work with her in the county as definite help along their special lines may be needed. These State specialists are indeed quite active in suggesting to the counties programs of work which may be developed to advantage.

The nutrition program in the States is influenced by both the nutrition specialists and the health specialists. Thirty-eight States at the present time have 55 full-time nutrition specialists. Only seven States have health specialists. These State specialists not only outline programs of work and work with the county home demonstration agents but they also function in those counties where there is no home demonstration agent, and, unfortunately, there still are many such. They work with the county agricultural agent in case there is one, otherwise directly with the women themselves. The work is carried on through the cooperation of trained local leaders selected from among the outstanding women in that community.

There are certain limitations in the service that can be rendered by the home demonstration agent, and these should be carried carefully in mind if the program is to be worked out on the basis of the service she can perform best.

One woman to a county cannot reach all the homes of that county with the solution of their many problems without spreading her time pretty thin. Various organization devices are used to increase her efficiency. Community meetings, homemakers' clubs, and the training of selected local leaders who in turn become responsible for furthering the work, are important features of such organization.

Many different problems are met. One woman cannot give the help needed on them all, even with assistance from the State college specialists. The county advisory committee usually helps plan the program for the year, indicating the subjects they wish emphasized, and the work is largely guided by this program.

Another limitation lies in the training of the home demonstration agent. In order to meet the varied problems which face her she must have a somewhat general training. She has had home economics training, with the essential scientific background. She is getting now, in many cases, training in child care, which we have been discussing. She must know the problems of rural life. The fundamental problems of nutrition and home hygiene she is well qualified to handle, but the more professional aspects of the health problem she cannot be expected to handle with her training. She can, however, render a valuable service to the home by putting the persons there in touch with the agencies that can best give them this specialized help. A full appreciation of the value of this service helps the home demonstration agent to take her place in a cooperative health program for the community and State.

If she is going to function best she must keep in touch with other specialized agencies and use them to the highest advantage. It is important that each should know more of the work of the others.

The State and County Councils, made of representatives of the different interested agencies, are a valuable means of accomplishing this. Several States reported such conferences. I think particularly of California and Colorado as having organized especially well these cooperative councils.

The foundation of any health program lies in the home. That has been emphasized over and over here. The importance of considering the child in relation to the home was brought out yesterday and again in the preceding talks this afternoon. The home demonstration agent, with the extension organization back of her, is the most important single agency for the betterment of the rural home. She can make her best contribution to the rural health program by developing home conditions that are right, and establishing cooperative relationships between the home and the specialized agencies which are in a position to help. She should pave the way for the specialized health worker. It is her job to make the condition in the home such that the health specialist can work most effectively. She not only trains the child to drink the milk but is in touch with dairy specialists to see that there is a milk supply and that it is safe. Correct food habits cannot be gratified without the food being available. Better gardens, the poultry flock, better markets, and the family cow, all have their place in the nutrition program, and the home demonstration agent through her place in the extension program is in close touch with the specialists that provide these.

The plan of work for the home demonstration agent is one of education through demonstration of approved practices. These demonstrations may be given to the individual homemaker in her kitchen. Lecture instruction may be given to groups of homemakers who try out the practices in their homes and report the results. A series of lessons may be given to clubs of homemakers. Or a small selected group may be given intensive training as local leaders for certain projects with the understanding that they in turn will pass on this instruction to other groups.

With this general background of her work in mind, what actual contribution is the home demonstration agent making to the county health programs at the present time? In order to determine this, a letter was sent to the extension specialists in nutrition for a report of the work in their States, and I am going to mention very briefly in the three minutes that are left me some of the things that they are doing.

Since the letter sent out asked for information as to definite health activity with mothers and pre-school children, many projects were not mentioned which would help develop fundamental health conditions in

the home. The greater number reported the health work as being done in cooperation with the various units within the State, such as the State board of health, or other specialized health agencies.

Practically all of the States have well-defined food selection projects, and in many these are tied up with efforts to see that the necessary food is made available through better gardens, canning projects, a wholesome milk supply, and the poultry flock. Some reported special emphasis on the diet of the mother during pregnancy and on infant and child feeding. These are developing in certain States as definite projects for those particularly interested. Some reported special emphasis on diets for special conditions, as constipation, and over-weight and under-weight. These last we hope were done in cooperation with a physician, where one was available. Four States reported special correspondence courses with expectant mothers and mothers of young children.

The reports indicate a tendency to work with the school children because they are brought together in groups. The school lunch furnishes a basis for developing correct food habits. Since the mothers usually cooperate in the school lunch projects, this work should be reflected in the home, not only through better physical condition of the child, but through the education of the mother and better food habits established in the school children.

The home demonstration agent in many cases has cooperated in the organization of the county for a pre-school clinic, giving what advice she can in planning diets, in cooperation always with the physician, and then assisting with the follow-up work in so far as her time will allow. The wise home demonstration agent knows her community and makes use of all its trained resources. She is not so much a fountain head of information as she is a transmitter.

Several pieces of work seem to be sufficiently valuable to have special attention called to them.

Montana has had once each year what they call "Mothers' Training Camps." The mothers are brought together at specified places for a week, during which time intensive instruction is given them on various home problems. At these meetings the State health workers are given an opportunity to present specific problems which have to do with bettering the health of mothers or young children. There might very well be connected with such a project specific training in child care and training, the mothers being urged to bring the children with them, and specialists being on hand to supervise and direct the work, very much in the same way that Miss Roche indicated that they are doing in Grand Rapids.

Utah holds three-day institutes at various places over the State, and a two-weeks' school for training project leaders at the State college. Utah is also cooperating with other health agencies in health surveys. Such surveys are very much needed as a guide and a stimulus to well-developed health programs. Utah has probably gone further than many of the other States. As was referred to yesterday, Mrs. Maycock is trying to give the mother a picture of the child that is really healthy and strong.

It is interesting to note in the report from Minnesota that a nutrition worker has been appointed in the State Hygiene Department as the result of nutrition surveys undertaken by the home demonstration agent and the State specialist cooperating with various women's organizations.

Florida reports an interesting cooperative program in which the home demonstration agent functions by giving nutrition advice and follow-up work in the home as a part of a larger health program.

California and Colorado report well worked out cooperative programs with frequent meetings of all interested organizations. They also have a special project on children's teeth, which is being developed in certain communities in cooperation with organizations of dentists. This should develop some very interesting material.

Georgia, by arranging meetings and furnishing transportation to the Child Hygiene Division of the State Board of Health, is making a very definite contribution to the program.

One difficulty which several of the States report is that of reaching the young mothers. They seem too busy to take the time to attend meetings outside the home. This points to the necessity for making better provision for taking the work to them or for getting them to the meetings and making arrangements for the care of the young children during such meetings. I wish very much that we could so organize this county work that there could be a movable nursery school held in connection with the meetings to which these young mothers come. This would serve the double purpose of a demonstration for the mothers and a means of providing for children who must come if their mothers come.

In conclusion, I want to call your attention to the fact that we have in the home demonstration service a definite organization set up for educational work. We need specialized material, and it is an agency through which you can transmit to the mother much of the material which you have and which should be made available to rural women.

RURAL HEALTH SUPERVISION OF BABIES AND YOUNGER CHILDREN

FLORENCE L. MCKAY, M.D., Director, Division of Maternity, Infancy and Child Hygiene, Department of Health, Albany, New York

The standards and methods of rural work for infants and pre-school children are still in the formative stage. All types of public health work are less advanced in rural communities than in urban, with the possible exception of tuberculosis which is generally quite well-established in a county program.

Always difficult of establishment, the infant and pre-school program is therefore particularly so in a rural community, where no other type of public health work, not even tuberculosis, has preceded. The problem of the education of the rural public to the need and value of health work of this nature is therefore one of the first essentials. Rural public opinion is slower of conviction than urban, but public health agents in this field must not become discouraged, for, once aroused, rural interest is usually better sustained.

The objective to be reached in this program is the promotion among mothers, doctors and nurses of a "Keep Well" service for babies and pre-school children, or, in other words, the establishment of continuous adequate medical and nursing health supervision of infants and pre-school children to keep them in good health and to prevent defective development.

One essential feature of this program is a careful selection of the area as to size and population. Ideally it should be limited to only so much territory as can be covered in the adequate conduct of a thorough, well-rounded program. In short, the ratio of both area and population to staff personnel should be carefully studied. A good program in a limited area sells itself to adjacent territory and makes extension of the work easier. There are, however, certain circumstances which occasionally make it necessary to do less work over an extended territory, especially when it is important to arouse public opinion in order to secure financial support. Such cases necessitate a definite public appeal by giving service, however slight, to as many individuals as possible. This means that for a temporary period, at least, the program cannot be as well-rounded as might be desired.

The essential personnel for this work consists of an energetic health officer and a well-trained public health nurse aided by local physicians and such lay assistance as may be available.

Most of the active field work is done by a public health nurse who is really the keynote of the whole program. Its success or failure de-

pende upon her ability and common sense more than upon any other one factor. The additional assistance available in a county usually means a home demonstration agent or county child welfare agent, both of whom give valuable assistance. Other helpers are volunteer workers who may be found among the leading women of the community who are interested in matters of public health. These are particularly valuable in guiding public opinion, arranging for public meetings and organizing motor corps transportation. This latter is of use especially in follow-up work after children's consultations, as much of the nurse's time may thus be saved in transporting patients to doctors, dentists and clinics.

The main activities undertaken in the attainment of our objective may be classified under two heads—special and general. The special types deal directly with the infant and pre-school child and comprise such activities as the following: (1) Organizing cooperation in service with local physicians; (2) promotion of breast feeding; (3) improvement of birth registration; (4) home visits by the nurse for instruction and demonstration to the mother of methods of care for the infant and pre-school child; (5) periodic health examinations by physicians at intervals of from two to three months for infants and about every six months for pre-school children; (6) follow-up visits by the nurse for securing the correction of defects of examined children; (7) training of the pre-school child in health habits; (8) establishment of mother and child hygiene stations or centers for group instruction and health examinations.

These eight varieties are further classified into individual work and group work. In rural communities most of the work is of the individual variety, particularly during the period of initiating the program; for the organization period of a maternity, infant and pre-school program is time-consuming and may well be a full-time job. The health officer may enlist the cooperation of physicians by presenting the program at a medical meeting and explaining the service made available to them as well as the service which they can render the community, but he can seldom reach all physicians in this way and this effort must necessarily be followed up or completed by personal visits. The consultations for periodic health examination of the children are of course necessarily group work but demand both individual and group advance work among physicians by the health officer.

The field work of the nurse consists chiefly of individual home visits and much of her program can be put across by this method. In the first place, she should visit every physician in the community and explain the services which are available to him through her. In fol-

lowing up registered births through home visits, the promotion of breast feeding, improved birth registration and the instruction of mothers can be accomplished, and during home visits for the correction of physical defects, instruction of mothers and training of the pre-school child can be given.

Group work in the nurse's program is difficult and slow of development in a rural community because of distances, poor roads and insufficient household help, as well as because of a naturally slow adjustment of the rural mind to a new proposition. Where an active home bureau organization exists the home demonstration agent can be of great assistance in promoting group interest. Group work is less expensive; it is a great saver of the nurse's time and strength and is also stimulating to the mothers, but it can never entirely replace home visits. The organization of the child hygiene station—itinerant or permanent—forms the basis of group work. Here the periodic examinations are conducted by doctor and nurse and all types of generalized group instruction are given.

The general types of work deal less directly with the children in question and more directly with the general public. They include such activities as the following: (1) Making a survey of the community, which shall include the infant and pre-school death rate and morbidity conditions, existing facilities for the care of infants and children, local sanitary conditions and local organizations which might be interested in health work; (2) providing lectures or clinics for medical societies; (3) organizing classes through Mothers' Health Clubs or mothercraft classes for group teaching of mothers as to methods of infant and pre-school care; (4) establishing Little Mothers' Leagues; (5) distributing literature; (6) securing cooperation and needed assistance from local organizations for the promotion of the program; (7) conducting exhibits and otherwise disseminating information at public gatherings such as county fairs, industrial exhibits, church fairs, meetings of Home and Farm Bureau groups, Grange and Parent-Teacher Associations.

With the exception of the community survey made by health officer and nurse, the general types of work for the health officer and physicians are almost entirely of the group variety, as, for example, the lectures and clinics provided for medical societies; the health consultations, the meetings of local organizations for securing assistance and the dissemination of information regarding group activities. The nurse's general work is also chiefly of the group order and is largely conducted in the mother and child hygiene station where Mothers' Health Clubs, Little Mothers' Leagues and other methods of group teaching are part of the local station work.

The relation of the State department of health to the rural infant and pre-school program is in general that of rendering actual service in organizing and establishing such a program, supplying personnel, furnishing standards of work, giving instruction in methods, providing equipment for health education of the public, making surveys and studies and maintaining expert advisory and supervisory relationship.

Assistance in personnel in many States takes the form of furnishing public health nurses to communities on either full-time or part-time basis, as well as assisting communities to find suitable nurses who are to be paid by local funds. It also includes the payment of local physicians for conducting health work of this type in their communities. The State staff also gives demonstrations of infant and pre-school consultations.

Standards of work and a general outline for its conduct may be provided by the State department of health to the nurse who goes into any community to organize her program. Specialized nurses from the State health department are sent to communities to help the local nurse plan her program and organize her work. They remain any desired length of time, assisting her in any way which may be indicated, such as in establishing an approved record system, or teaching breast feeding technique or any other phase of the work with which she may not be familiar. For nurses who are lacking in specialized training, instruction in the conduct of infant and pre-school activities may be made available through State department of health teaching centers where methods and standards are being worked out. This may be made more accessible to the local nurse if the State assumes her expenses while she is under instruction and also carries on her local work during her absence. Conferences, both local and general, are held for nurses at intervals for the stimulation of interest and for instruction in methods of infant and pre-school work. These are conducted by the State department of health, and the expenses of the local nurses may be carried by the State.

Special service may be given to local physicians and health officers through lectures or institutes conducted by leading pediatricians whose services are furnished by the State. These are designed to promote the health supervision of children by local physicians. The State also furnishes literature to physicians for their use among the mothers of their private practice.

Nutrition instruction may be given to nurses and mothers through the State department of health or through cooperation with the Home Bureaus.

Help may be given by State field agents in organizing lay committees for backing up and promoting the health program.

Surveys of local communities or special studies of any phase of work may be made by the State department of health upon request.

In addition, the department usually furnishes free of charge literature, record forms for nursing reports and for child hygiene station work, films, slides, posters, exhibit material and lecturers. It may also send samples of new publications of national organizations so that the local nurse and health officer are kept in touch with recent available literature pertaining to their work.

In short, the service of the entire personnel and equipment of the child hygiene division of the State department of health should be at the service of the local health officer and nurse in organizing new work or extending their health program for infants and pre-school children.

DISCUSSION

Dr. Margaret Koenig, Associate Director, Bureau of Child Hygiene, Little Rock, Arkansas: Our Bureau of Child Hygiene has been established two years, and has become known over the whole state, especially in southeastern Arkansas. Our activities there centre around the travelling child health unit, consisting of two nurses, myself and a chauffeur. We have two cars, and we have a portable motor for showing pictures. A nurse goes about three weeks in advance and helps the people organize the work.

Then we set up our conference. We have had as many as three and four hundred people at our conferences, and I think Arkansas is particularly fortunate in having a splendid agricultural extension service. We have had county home demonstrations and workers for a year, and found few physical defects, and less underweight in the places where they had been. At the end of every conference we have special clinics, eye, or ear, or orthopedic, and some doctor comes for that purpose.

We have another problem, one that confronts us in all southern states, and that is the midwife problem. We are holding classes for them. A nurse is making a survey of the midwives of the state. We are planning a state registration of midwives.

PRE-SCHOOL STUDY FOR MOTHERS

MARY H. WEEKS, Chairman, Children's Bureau, Kansas City, Missouri

Of all animal young, the human child is the most dependent upon its mother and for a longer period. A trite saying, but how do we act on it? We bring a few babies with their mothers into centers to examine them and care for them. We send a few nurses into a few homes to teach mothers—nurses practically untrained in the mental processes and development of the child, processes upon which habit training must be based. We organize a few baby clinics where a few mothers and a few children are reached on individual lines. All are good individual case studies and experiments, but never stress sufficiently the basic cause of the bad physical or mental development of the child or suggest how this cause may be removed. We have not handled vigorously or courageously enough the root of the whole matter. In our furore for individual cases, we have neglected the mass. Miss Jean says, "While we go on with the health program, we must be careful or we will find ourselves on the mountain top looking back at the people below. We can only go as fast and as far as the people go."

Dr. Thom says truly that the pre-school years are the years in which personality defects can be handled most successfully, yet few parents with a young child have as much information given them about the care of the child as a Ford owner is given when starting out with a new car. The garage man will give him ten lessons on how to protect the car. The salvation of the pre-school child lies in giving instruction to parents, teachers, dietitians, nurses, and all other individuals who are in intimate contact with the pre-school child. They should have at least ten lessons in what and how to run the child so that he won't get stalled. As the baby is most dependent on its mother for life and training, we place her first on the list. A few physicians, a few psychologists and psychiatrists, a few public health nurses and other social workers joined together in an association or working separately do not guarantee satisfactory preventive work for children; the real test is the extent to which the masses of mothers participate in the education for parenthood; in the equality of opportunity to acquire the necessary information.

Is it not time to create the social consciousness which will recognize that training for parenthood is as truly vocational as bricklaying or electrical engineering, and much more vital to the commonwealth? Through this consciousness we might create a demand for the public

handling of this education, so that it might be given, not alone to the favored few, but to all.

Mothers want their children to be, not only physically fit, but mentally normal. The two are interdependent, success in physical care of babies being often dependent on training in right mental habits. Yet even quite intelligent people often know nothing of the mental processes upon which such habits must be based. The child experts who have been investigating the mental processes of little folks for many years, the child specialists who understand all the physical processes, and we everyday people who have been studying training methods, have certainly gone far enough in knowledge to be able to put into simple words the general stages of mental and physical growth through which every child passes from birth to school age, and to be able to tell what habits may be initiated at the different stages and by what methods. If we could get these fundamentals into the minds of all prospective parents, most of the need for disease and habit clinics would pass and many home and school problems would be eliminated.

During the past six years, the Kansas City Children's Bureau has made a series of experiments in classes for mothers of children of pre-school age because it felt that the individual methods necessarily adopted in its examination centers and in the usual disease and habit clinics, indispensable as they are, were not reaching all the mothers who needed the information. Three years ago, the National Congress of Mothers, coming back to its original purpose, began to stress the importance of circles for mothers of little children. The time seemed propitious for making more systematic and definite experiments as to whether mothers would come regularly to classes on care and training of young children, just what kind of topics would hold their interest and attendance, the best way of presenting various topics, and whether systematic presentation was possible, if the largest interest was to be maintained.

The purpose was two-fold. We wanted to help the young mothers of today: but we specially wanted to make them feel that the information given in these classes is what they should have had before their babies came. We would thus create in the public mind the consciousness that such education is basic and of more vital importance to the community than—say carpentry, mechanics or any academic education now given by the public schools. Thus we hoped to create a public demand for such teaching.

Manifestly such an experiment needed leaders who had some training for the work. The average haphazard speakers who talk out of what they think is knowledge and experience, but which is in reality mere

tradition or casual ideas gained from reading mediocre articles on child training would be useless.

We chose four college graduates as our leaders, three of them mothers—one a graduate nurse from the Teachers College of Columbia University who had had experience in community center work. Two of our leaders had taken the full dietetics courses and one of these had had an extended experience in the physical examinations as given in the Children's Bureau.

Our programs were made to cover four periods—prenatal, nursing, weaning, and the third year, each period covered by needed topics. With each topic goes a printed sheet containing all the subheads covered by the talk and a few references to authorities, which is given to each mother to take home. The talks are arranged in logical order, and continual reference is made to previous talks, in an effort to give, not a lot of disconnected units, but a logical whole.

Each speaker has been required to fill out a report on each meeting covering interest created, amount of discussion, questions, suggestions, attendance and weather.

The circles were organized by school districts the better to enlist the assistance of Parent-Teacher Associations. Six were carried on the first year with an attendance in each of from 6 to 18 twice a month. All took the regular courses covering the first four periods of child life. The past year, 23 circles enlisted a membership of from 15 to 30. A total number of 1244 mothers heard the talks. Not all the circles took all the courses since some circles involved mothers of children from 3 to 6 only. In some of these cases, a prenatal division was held a half hour before the other. All circles were required to take the talks on six stages of development, habit training and self-control.

Many people think that good work can be done with lists of books and leaflets. We use everything of this kind but our experience is that, valuable as they are, the personal talks count for more with the average mother. As one of our mothers said, "When I am through my work I am too dead tired to read. It is a tremendous relief to have an expert talk to me on the things I want to know, and the experience and questions of the other mothers help."

The demand for circles is increasing rapidly. Eventually there will be at least one in connection with each of our 63 Parent-Teacher Associations and in each of our parochial schools in which the bishops permit us to organize. We hope that there will be one for each of the four periods of baby life, in each district. By that time, we shall have created the desired social consciousness.

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ESSENTIALS OF COMMUNITY ORGANIZATION FOR CHILD HEALTH WORK (Continued)

Section 2. Health Work in the Schools (contributions of specialists in a school health program)

Presiding, THOMAS D. WOOD, M.D., Professor of Physical Education, Columbia University, New York City

Introductory Statement by Chairman

1. School Medical Inspection

HAROLD H. MITCHELL, M.D., Director, School Hygiene, Fall River, Massachusetts

2. School Nursing

ELMIRA W. BEARS, Secretary for School Nursing, Division of Nursing, AMERICAN CHILD HEALTH ASSOCIATION

3. Health Education in Special Fields

a. Relation of Home Economics Department to Classroom Teacher

ROSE SHONKA, Supervisor of Home Economics, Lincoln, Nebraska

JOINT SESSION

Summaries of Sections 1 and 2

Presiding, TALIAFERRO CLARK, M.D., Surgeon, Medical Officer in Charge Field Investigations in Child Hygiene, U. S. Public Health Service, Washington, D. C.

WHAT SCHOOLS SHOULD DO FOR THE HEALTH OF CHILDREN

Presiding: THOMAS D. WOOD, M.D., Advisor in Health Education, Teachers College, Columbia University

Introductory Statements by Dr. Wood: The schools should make health the primary objective in all education. This is strikingly recognized in the authoritative report on "Cardinal Principles in Secondary Education," prepared recently by a Commission of eminent educators and issued as a government bulletin.

The most valuable and neglected resource of our nation is the health of children. The school must safeguard and improve the children's health, by all possible and practicable measures, and all essential measures for the health of children and teachers are possible and practicable for every school.

Schools should establish thorough health supervision and health care to enable Every Child to attain the maximum of his native capacity for health, for education and for usefulness.

Health supervision should include daily health inspection as a protective measure; monthly weighing, periodic measurement of height and test of health to secure a continuous health and growth record of each child; to discover and correct health defects; to remove handicaps; to make the child free to grow and develop; free to discover the best of himself in physical, mental and social personality. Such freedom and liberty, such equality of opportunity the Declaration of Independence and the Constitution of our Country guarantee to each of its potential citizens in spirit and by implication.

The school must surround the children with a safe and healthful *environment* in schoolhouse and grounds; in furnishings and equipment; in care and upkeep of buildings; so that the children in the schools may be supplied with air, light and water, with clean surroundings not only as good as the plants and animals enjoy, but as favorable in influence upon body, mind and character as children need for the achievement of their best development.

Again the school must provide health education, health training of all children to establish in each child the essential health habits, attitudes and knowledge affecting the child's health and the health of his community.

In the next place, schools must make sure that children have space, time and full opportunity for healthful play and work; for wholesome outdoor life and activity; for the sake of health, of mental development, of social and character training, which in many large and fundamental elements will not be attained except through the big activities and experiences which belong to a rational program of physical education.

Another essential service of the schools is to secure full and effective cooperation of the homes in all efforts aimed at the welfare of children.

Nowhere do the schools achieve greater failure, and waste more effort, than in attempts to promote health of children without the essential, the indispensable cooperation of the homes and the community at large. "Too many cooks spoil the broth," and much more surely, divergent efforts of the schools and other influences outside of the schools produce tragic results in the careers and outcome of child life.

The health service of the schools to the children, if successful must be an integral part of a unified program of education, which is healthful every minute of the day, in the work of every teacher in the teaching of every subject, in short, in every influence and experience of the school.

Finally, the strategic and vital factor in determining the worth of school service to child health is the teacher. The teachers in the schools of the country who are genuinely interested in child health and who have the professional training to give intelligent and effective health service in the schools are few, but they are rapidly growing in numbers. May their tribe increase!

The schools of the country are awake to the idea of health. They are aware of the general importance of health, but they are not capitalized nor equipped with material facilities or technically trained personnel, to approach real efficiency in achieving the first avowed goal of education.

The American Child Health Association wishes to help the schools to improve in all possible ways their health service to the school children of the nation. This Association is committed to the particular task of helping teachers to become better qualified for their part in the health work of school and community, believing that no feature of the nation's health program is more vitally important than the contribution which may be made by the teachers of the country.

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ORGANIZATION OF SCHOOL MEDICAL INSPECTION

HAROLD H. MITCHELL, M.D., Director School Hygiene, Fall River,
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For the sake of limiting our discussion it will be necessary to consider school medical inspection from the standpoint of the routine health examination alone—that is, the detection and correction of physical defects and the promoting of health through the physical examination. It must be emphasized, however, before limiting the discussion, that the control of communicable disease, the control and prevention of minor contagions, the promotion of cleanliness, good health habits, health education, schoolhouse sanitation, the hygiene of instruction, recommendations regarding the curricula, physical education, and so forth, are all closely related problems which demand a centralized supervision of all those phases of school health work, or a very close cooperation between health and school authorities. The opportunities for developing lasting appreciation in the child through the example of control of contagion in the class room, through the child's participation in the sanitation of the school plant, and through linking the health examination with preparation for the physical activities of the physical education division are correlated phases of the problem which demand an inter-relationship between health education, nursing, school administration, medical examinations and physical education, and therefore require thorough supervision.

Although we have had thirty years of school medical inspection, no one claims we have made the progress in our procedures that we should have. Except for the advent, about fifteen years ago, of nurses as a part of the staff, we can point to very few steps toward a more effective service. We have made tremendous strides toward extending the service into all parts of the country—thirty-five States have laws permitting or making mandatory school medical inspection and in some of the States where there are no laws we have as good services as where it is mandatory—but when we consider how thoroughly school officials have recognized the physician and nurse as a part of school administration, we wonder that we have not records that show real accomplishment in better health for the school child.

Of course, a few have made claims that there are less defects now than when they began their work five, ten or fifteen years ago, and assert as proof of their progress that children have fewer defects and are healthier as a result of school medical inspection service. But when we examine existing records, we are impressed with the fact that they will not stand analysis. In fact, so many inaccuracies exist in the vari-

ous measuring rods that we are inclined to doubt all the figures. Few of the examiners agree as to what a physical defect really is; the grouping of physical defects varies so that the total numbers of defects are useless records; skin diseases and numerous varieties of dental defects add to the confusion, and sometimes even defects and defective children are confused in the reports. It is with our propaganda as to the value of our service, based on individual case records of children who have been helped, and on our vague statistics that no one has analyzed, that the public continues to support "the wonderful health work for the children."

These statements may appear discouraging. Many will object that this pessimistic viewpoint does not give credit to the excellent accomplishments that faith assures us is deserved. Actually such a viewpoint is not pessimistic and our faith in service increases every year, but it is high time we faced matters squarely and that we made some progress toward accurate bookkeeping. The taxpayer has no such appreciation of what is accomplished in individual cases as have we who see the work going on every day in the schools. Then, too, we are conducting school medical work with a large variety of procedures—physicians making rapid yearly examinations or semi-yearly examinations, physicians making careful, thoroughgoing examinations only once or twice in the school career, nurses making the examinations, nurses making weekly rapid class room inspections, teachers sifting out the children with physical defects, nurses doing follow-up entirely by home visits, nurses limiting home visiting and getting corrections through conferences with children and parents at the school buildings, a follow-up service largely accomplished by competition in getting a clean bill of health among the pupils. We have no basis for comparing the efficacy of these procedures because we have no bookkeeping methods that permit comparisons. Do we not owe it to the work to organize an accounting system that tests whether one method will bring larger returns than another?

Some organization of school medical work has already been started. Within the past two years the Joint Committee of the National Education Association and the American Medical Association under the chairmanship of Dr. Thomas D. Wood has taken the first steps toward accurate bookkeeping through an analysis of what a physical defect is so that we may have uniform methods of recording the results of the examination. Another step along the same line was made at the 1923 meeting of the American Public Health Association through the presentation, for trial and experiment, of the Detroit scale for recording physical defects. This scale was worked out by the Committee on Health Problems in Education of the Child Hygiene Section of the

Association. We now have a number of schools about the country which have been using the Detroit scale or some modification of it. The next step will be an agreement as to the method of recording the corrections of the defects in this classification. The development of this phase of bookkeeping is a preliminary step to testing the efficiency of our various school medical and nursing procedures. We also need a large number of schools which will try out this record-keeping plan and experiment to perfect the details.

The complaint is frequently made that the examination is incomplete. School superintendents criticize perfunctory inspections as of no value, even though numerous corrections of the obvious physical defects result from the nurse's follow-up service. Other school authorities are enthusiastic over the rapid yearly examinations that detect only the more obvious defects. These schools are often too satisfied with their kind of inspection to provide for the thorough examination that is a true demonstration of what a periodic health examination really should be. Confusion naturally results which seems to indicate a lack of clear-cut objectives.

Let us consider one thorough-going statement of objectives. The Health Education Conference called in Cambridge in June, 1924, by the Health Education Division of the American Child Health Association and the Department of Biology and Public Health of the Massachusetts Institute of Technology, stated that "the aim of the health examination of the child is to provide for every child a chance to achieve the limit of his endowed capacity for well-being." The conference stated that the function of the physicians should be:

1. To provide guidance toward better health through education of the children.
2. To provide an examination service which (1) discovers all physical defects, diseases, incipient conditions and tendencies toward ill-health among school children, (2) finds sources for remedy.

The statement further adds that the function of the teacher and parent as participants should be:

1. To be present at the examination and to supply information relative to history and habits of the child.
2. To secure the cooperation of the children through class and individual instruction.
3. To stimulate and secure correction of physical handicaps.

This statement represents a more thoroughgoing use of the physical examination than any hitherto developed by either health or public school departments. The large numbers of children to be examined, the number of defects to be remedied and the demand for economy in conduct-

ing the work has led to placing the emphasis upon the more outstanding physical defects, and the educational aspect of the examination has been neglected. If we are to make any real progress toward an appreciation of the value of the periodic health examination, we must make proper use of the opportunity offered us in the schools for demonstration to the teacher, child and parent. Recent reports from many cities reveal that very rarely is the parent invited to see the examination. In most cities, if the parent did see the examination, the effect would be unfortunate. They would probably consider the examination they witnessed of little value and would class all periodic examinations in the same category. The educational aspect must include actual consideration of the individual child's health habits, a thorough examination, and individual advice regarding the child.

This means that we must define two types of inspection: first, the rapid examination of children so as to discover and urge correction of the grosser physical defects, and, second, the examination that is designed to be educational to the child, the parent and the teacher. The first type of examination will be the immediate concern of those cities where there are large numbers of children suffering from correctable handicaps that need immediate attention, as in our industrial centers or in communities where many children have no medical care except in case of acute illnesses. We must thus give first consideration to these outstanding, handicapping defects, and, therefore, our first objective is an examination that will discover these conditions in as large a proportion of the school population as possible. This represents the bulk of school medical inspection service today. In order to cover the ground and provide proper follow-up work with the resources of the average city, our objectives must be limited. The examination must therefore be rapid and not the thorough study of each child that is necessary to determine the limit of his endowed capacity for well-being. Even such an examination benefits the recipients. Our problem is largely to perfect an organization that makes economical use of the nurses' and physicians' time, and that provides records that show what is accomplished and yet requires a minimum of effort in recording.

The second type of examination may be planned for only once or twice in the career of the child provided the problem of grosser correctable defects is large. Sometimes it must be omitted entirely until after the work is far advanced or funds are available to handle the more immediate problem or our first objective. Private schools, or public schools in wealthy communities, suburban cities where well-to-do parents send their children to the public schools and demonstrations by private health agencies certainly should provide this more thorough-

going analysis of the child's health and use the examination as an education opportunity.

This kind of a thorough overhauling should also be considered educational in the sense of creating a demand for more frequent periodic examinations by private physicians. Such a demand will decrease the necessity for and the frequency of examinations by public authorities. Demonstrations and post-graduate opportunities for physicians that will help to develop a proper technique among private physicians to meet this demand created by the school educational examination must be an equally important part of the public health program.

With a differentiation between these two objectives of a school medical and nursing service, we should begin to make progress, first, in the organization and administration of correction of the handicapping physical defects, and, second in the development of educational technics for promoting periodic health examinations. With our first objective clearly in mind and with a sincere desire to develop an accounting system for recording results obtained, even a few cities might make an agreement to exchange experiences and to attempt similar procedures and thus bring forth proposals for testing the efficiency of our methods. Such experimenting would do more than years of arguments at national conventions. Similarly, we should soon find several cities with a worthwhile experience in promoting periodic health examinations through the demonstration of school examinations and their experience would promote the second objective.

ORGANIZATION OF SCHOOL NURSING

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School nursing, like school medical inspection, is being organized under a diversity of methods and administered by both official and non-official bodies. At present, the greater part of the work in this country is supported by official funds. We find the nurses working:

1. Under health departments, with or without nurse supervision.
2. Under boards of education, with or without nurse supervision.
3. Under private groups such as the American Red Cross, Tuberculosis Associations, Visiting Nursing Associations, and local civic clubs.

It is small wonder that the service has not been uniform in its development throughout the country, and that great diversity of opinion still exists among health and school people, as well as among the nurses themselves. It is not likely that the question will be settled in favor of either the health department or the board of education, because variations in local conditions and State laws make it impossible to form any universally acceptable rule. An excellent arrangement was suggested by the Advisory Committee of Health Education of the National Child Health Council, in their report on "Health of School Children," published in 1923. It was advocated that a joint supervision of these two municipal departments be arranged, vesting the responsibility for all phases of the school health work in one well-prepared person, who should be equally responsible in turn to both groups, and should enjoy all the power and privileges of both groups. There are a few places in this country where this experiment is being tried, in one form or another.

As a basis for discussion of present and future organization of the school nursing service, it might be well to quote the conclusions reached by the "Special Committee to consider duties of the physician, nurse and teacher in relation to the examination of the child," which was appointed by and functioned during the 1924 Health Education Conference at the Massachusetts Institute of Technology, last June. The aim of the examination, as stated by the Committee, is "to provide for every child a chance to achieve the limit of his endowed capacity for well-being" and the functions of the nurse in relation to this basic part of the school health program are:

1. To assist the physician at the examination.
2. To assist in interpreting results of the examination to child,

teacher and parents in school and home through instructional conferences.

3. To stimulate and secure correction of physical handicaps.

This clear-cut statement of the work which the nurse develops from the health examination does not include all of her problems but it represents the major part of her service. When she is seeking the best methods of executing her duties, the following questions are among many that she asks:

1. What type of health examination is going to be given in our public schools in the next ten years? Are we going to encourage the thorough health inventory as a part of our permanent school program, or only as a demonstration of the educational value of such an examination, until such time as our present school children have become the intelligent parents of tomorrow? Will the family physician and the community health clinic be the logical agents through which the examinations may be obtained in the future? In other words, will the parents or the schools finally assume this responsibility?

We are preaching "a health examination for everybody once a year" and when physicians are ready and families desirous, are we going to separate the school-age child from the rest of the family, in emphasizing this established necessity for 100 per cent fitness? Perhaps the growing child needs only three thorough examinations during the years between six and sixteen. That question will have to be determined after further experimenting. The answer to this first problem will greatly affect the trend of development of the school nurses' work.

2. Are urban school nurses going to continue to care only for the school-age child, or will they find it advisable to extend their interests and labors to include all child health nursing? This is not quite such a question in the rural field where community work is usually the rule, the schools often being the avenue of approach to a general nursing program. In the light of good constructive family teaching, it would seem better to care for the entire need, rather than to confine the efforts of special nurses to a certain age-group. There exists much diversity of opinion about the relative values of both types of program as well as some administrative obstacles. General child health nursing would hardly be organized under a school department, and therefore, would constitute an argument in favor of health department supervision.

3. How is the health education program for the classroom, which places the bulk of responsibility for its execution upon the teacher, going to affect the scope of the nurses' work both at present, in places where it is functioning, and in the future, when it has become routine for all progressive systems? As teachers become more interested in and better

prepared for health teaching, two things must happen: first, the nurse will spend less time in the schoolroom, and secondly, there will be greater need for her services in the home. As the classroom gives more adequate knowledge of the ways and means for attaining normal development, and more instruction in how to maintain it, there will be a corresponding demand from the home for similar knowledge and instruction, which the nurse is equipped to meet.

4. Are communities going to ignore the need for supervision of the parochial and private school population? Where this need is met it is usually necessary to place the school health work under the health department, for there is no doubt that two separate school health programs in one community are less efficient than one uniform program supervised by a single group, or better still, under joint control. Several of our largest cities are maintaining two distinct school health programs.

In this discussion, no argument for one or the other type of school nursing administration is being made, except as it relates to the objective which the school nurse feels she must find for herself if she is to maintain a useful and dignified place in the school system. In facing these outstanding controversial points, we are at present finding little solution. Two conclusions in relation to the trend of the school nursing development might be reached, at least:

1. That the school nurse of the future will have fewer duties within the schoolrooms.

2. That the school nurse is going to find home instruction the most important part of her work. With emphasis placed on periodical health examinations; with the recognition of the need for a more community-wide child health program; with the transference of responsibility for classroom teaching to the shoulders of the teachers, and with the increasing demand from parochial schools for health instruction, it is very apparent that the home asks and the situation demands the best and most thorough kind of health education through instruction and through demonstration. From another point of view, hospitals, dispensaries, and other curative agencies are requiring more complete information regarding the homes of their patients, as well as an interpreter of their service to the community. The nurse is usually this link. The family physicians are going to urge better habits and environment for their families, and again the nurse is needed.

The school nurse has seen the health program grow through its various transition periods from pioneer days and she still finds demands for service that encroach upon the fields of physicians and teachers. She is desirous of finding her objective and standardizing her program.

RELATION OF HOME ECONOMICS DEPARTMENT TO CLASS-ROOM TEACHER

ROSE SHONKA, Supervisor of Home Economics, Lincoln, Nebraska

How can the relation of the home economics department to the classroom teacher help to promote health education in the school? That can best be answered by considering two other questions? First: What has the home economics department to give? Second: What are the needs of the classroom teacher? How can she become more effective in the promotion of health education?

For a number of years our schools have been saying, "Let us make health one of our outstanding aims." That means health in the broadest sense; health of the individual in all his life relationships; health in the home, in the community. Two of the most representative organizations, the National Education Association and the American Medical Association, are cooperating and promoting a program of health education in the school with a force that is bound to bring most desirable results. From coast to coast school systems are definitely organized for this purpose. In many of the systems special workers are charged directly with the responsibility of promoting health education. These workers are the school doctor and school nurses, the teachers concerned with the building of health through play, recreation and exercise, and the home economics teachers. The work of all of these is expected to be re-enforced by the regular classroom teacher, who, up to the present time in most cases, has had very little or no specific training for the teaching of health. In other words, her effectiveness depends upon the help she gets from her co-workers, and what she picks up, so to speak.

Viewing the splendid accomplishments in the teaching of health, and considering the possible achievements, we are led to propose that every teacher be a health teacher. It is not the idea to replace any of those directly connected with health education, but rather to extend to the teacher the fundamental principles of health, to enable her to be of greatest service to the child. This means a cooperation of all the forces.

In this cooperation, in what specific way can the home economics teacher or department help? The study of home economics centres around the problems of a home viewed from the standpoint of health, social, economic and æsthetic values; it is also a study of the relations of the members of a family to each other and to society. This definition calls attention to a study of the home in relation to a number of values. This paper will dwell only on the health values. The home eco-

nomics teacher is sensitive to all conditions that make the home a healthful place in which to live. When is a home a healthful home? When every member of the family, child or adult, is properly fed, clothed and housed; when every member of the family, child or adult, gets the right amount of rest under favorable conditions; when every member of the family finds it possible to have on his daily program time for recreation and exercise; when attention is given to the formation of health ideals, health habits, health attitudes, health information and health practices in children. It has been stated that our schools are organized for health education. Are the homes at large conscious of performing this function? We are ever studying and evaluating the function of the public school as a force in the advancement of civilization. For this we have all kinds of organized agencies. What is the agency that is studying, evaluating and promoting the home as an institution, a force that should also be vital in the advancement of civilization? The agency nationally organized for this purpose and represented in most school systems now by the home economics teacher is the National Home Economics Association, which, in brief, stands for a study of the home in all its relationships. Home economics education is not something tacked onto the school, it is not apart, but is a part of the entire educational scheme. With this principle in mind, the closest cooperation between the home economics department and the classroom teacher is desirable.

The home and the school are the two places where children of school age spend most of their time. Both should tend to re-enforce each other. Both should be healthful places in which to live. Both should help to develop those ideals, attitudes, habits, and appreciations in relation to the building and maintaining of health. Both should aim to translate health information into actual practice. This re-enforcement is frequently difficult because the home does not provide the proper food for the child; the attitude is not always wholesome; there is no defined program for rest, recreation; poor examples of living tend to tear rather than build the health program outlined by the school. It falls then within the province of the home economics department, through the Parent Teachers Association, the home economics teachers and classes, to build this wholesome attitude on the part of the home toward the entire program of school health, especially as it may be carried out in the regular class room. We need to extend to the class teachers the principles of health as they tie up with the various channels of teaching. Such subjects as industrial geography, community civics, applied arithmetic are teeming with opportunities bringing in the health relationships. The school lunch, school clubs, the art classes are alive to their opportunities for promoting health practices. We should be

thankful beyond words for what the classroom teacher is doing. Until it is possible for her to have more adequate training for health teaching, doctors, nurses, physical education teachers and home economics teachers must appreciate their opportunity for re-enforcing health work in school through the most direct channel to the child—the classroom teacher. We shall always need the special workers, but their effectiveness will be increased only as the effectiveness of the one closest to the child is increased. The challenge, then, remains with those commonly known as special workers. Can we answer the challenge?

DISCUSSION

Miss Rood: Referring to Dr. Mitchell's paper, would it be possible to inject into that health examination suggestion, the idea of having a yearly examination even though it were only the most rapid form of inspection. Can we make the child want to have it? I wonder whether it would be possible to appeal to Johnny and Mary, and giving them the desire to have the examination?

The Chair: Dr. Clark, will you answer that question, or any part of it?

Dr. Taliaferro Clark, U. S. P. H. S.: My observation is that it is difficult to stimulate the interest of the child, particularly of the young child, to demand a yearly or any other inspection. But we have attempted to do that by adopting a system of scoring whereby the child got a certain minimum health rating. We put down the name of each child in an ordinary class room. The score columns read "mouth," "eyes," "throat," "state of nutrition," and so forth. In making the preliminary inspection, if the child was found free from defect in any of these points we stamped a red star under that heading; if not, we used a symbol to show what was the matter. Then the child was told that when he got the defects corrected he would get a blue star. When he was up to weight, had been vaccinated and so on, with the red and blue stars to his name, then, with great ceremony, he received a gold star. Particularly in the lower grades that works well; there will be some child that will quickly get a gold star, and then all the others want one.

The United States Public Health Service will be glad to send you a sample of these charts, and a book of instructions for their use.

The Chair: Dr. Champion, in your opinion, how far may the annual health examination be used to interest the child, and to inculcate the habit of examination?

Dr. Merrill Champion, Director, Division of Child Hygiene, State Board of Health, Massachusetts: Health education as such, I must confess I think of as something different from the health examination. The health examination is merely the carrying out of a duty when a child must go from school to a free life under conditions which are certainly not for his best development ordinarily, and you have to do something to see that he does not break down under them. We use it I suppose as a sort of salve to our consciences and to help the parents correct any harm done by confinement in school.

It seems to me the health education side of it so far outweighs the other that it is just as well not to get the two mixed.

The child can be interested in the progress of his weight and his own growth but I am doubtful whether or not we could get a child interested in whether he had a heart murmur, or not, a matter very interesting to the doctor and more or less interesting to the parent. I am inclined to think that if I were trying to run the

two systems, I should keep them quite separate. I should have the doctor and nurse responsible for the examination of the child and the correction of defects. As a separate function altogether, I should try to interest the teacher in what we are referring to now as positive health. That may seem a rather meticulous differentiation, but when you think of the difficulty under which the doctors and nurses are working, it seems to me that for a long time to come we are not likely to get very far in pushing the attempt to interest the child in much of what we call clinical examination. I think I would interest the child in the matter of nutrition, in which it has been found relatively easy to interest him.

Dr. Wood, Chairman: I think I shall take the liberty, if you will permit me, to give a few words on a different side of this question, out of my own experience. It happens that one of the things I have been trying to do for twenty-five years has been to take part in health examinations. I am not sure that I understand exactly what Miss Rood had in mind, but I believe it is important not primarily to stimulate the interest of the child in health examinations but rather to promote the health supervision of all, adults, and babies, and children. I believe that one of the great values of the periodic examination of the child is that it accustoms him to examination as a matter of course, so that in adolescence or adult life he will not be particularly disturbed by its necessity.

There are plenty of children now who have had ten or twelve examinations. It is important that the health examination should not in any way emphasize or make prominent in the consciousness or interest of the child anything the child cannot understand with reference to his own condition and that he cannot intelligently do something about. We must recognize all that is sound in psychology and pedagogy here.

There seem to be three points. First, examinations are advocated. Second, children and adults should be led to become so accustomed to the idea of these examinations that they regard them without fear or emotion. Third, every use should be made of the opportunity for educational benefit that may be derived from the examination.

For a period of twenty years, in a certain school, I have seen the children, from the elementary to the high school, pass through the examination. Their parents have been invited to be present, and the examiner has taken time to have the parents understand all that seemed important and desirable. Informal plans of cooperation between parent and examiner have been worked out, so that parent and child went away with a right impression of what ought to be done.

I believe, without mixing the functions of teacher, nurse and physician too much, we must get very genuine articulation, integration, of these elements. The child is a unit, and we ought not to split him up, one part in the classroom, one in the clinic, one in the home.

Miss Rood: The reason I asked the question was because I wanted to get some new device. We tried muscle testing. Children like to know how strong they are—they are not interested at all in knowing what is the matter with them. If they can find out how to be stronger than the boy next to them, they will be only too pleased to have the examination. And if the boy wants it badly enough, the parents will see that he gets it, and they will do all that is possible to build him up.

The Chair: Is there someone who can give some other suggestion directly in line with this question? We know that numberless places are interesting the children in weights. Miss Rood speaks of the muscle tests. We need to be moderately sure

that we are using these items of interest, these objectives in the minds of the children, in ways that are rationally and scientifically sound, and in proper relationship.

Speaker: I should like to ask Miss Bears what percentage of a nurse's time should be spent in schoolhouse and what percentage in making visits in the homes.

Miss Bears: If your school teachers are doing effective teaching in the class room, and your arrangements are sanitary and in good order, the nurses might spend more time in the home and the community than in the school. If there is little foundation for healthy living in the school, I think the nurse should spend more time there. I do not think there can be a general answer to the question as to the division of her time.

The Chair: Personally I am very much interested in the relationship of the teacher of home economics to the work of the class room teacher. Is there any other question on this subject? I am anxious to have as full a discussion as possible.

Speaker: I should like to ask if anybody knows of a school that is giving the boy the same chance to eat properly as the girl. So many schools have the domestic courses and exclude the boys from them, and in consequence they do not get any of the teaching in that line.

Miss Shonka: I think the home economics teachers the country over are as much interested in this need of the boys. In Lincoln, Nebraska, we have a food class in the high school, we have not room in the junior classes. We find the boys do not always agree with us, though they seem to come to the laboratory willingly. In the four cafeterias of which I have charge nothing worries me so much as the way the boys eat. I think this is one of our very real problems, and something that we ought to work on. My idea is that these boys should take the courses in an academic room quite apart from the cooking point of view. Of course from a vocational point of view the cooking is useful to them, too, and as vocational guidance training, but the primary interest is on the food side. I would have this course in a class room. We begin there, where the interest seems to be, and try to lead it to a higher level.

The Chair: How many people here know of places where boys are taught cooking?

Speaker: The first cooking class for boys was in a Junior High School in Washington ten years ago, I believe. It was chiefly for camping, but it was found that a boy could cook a meal, eat it, and wash the dishes in the time a girl could get ready.

Speaker: I am in a part time vocational school in Kansas City which teaches the boys food selection, but not cooking. The boys and girls, separately, have forty minutes a day for hygiene work, and part of that is selection of suitable foods, to make them grow well and strong. The boys are more interested in that than the girls are, possibly because it is so new to them.

Speaker: In Kansas State Agricultural College we have a course on health problems of childhood. The senior girls take charge of different health classes in the public schools. We have a class in which we teach boys about food, and I find also that they are more interested than the girls.

The Chair: I have had the conviction for many years that if we could have, instead of compulsory military training, a universal requirement of citizenship, it should include the requirement that every boy of eighteen and every girl should know how to cook for a household and how to keep house, and every boy should

know the elements of camp cookery and emergency housekeeping. I think a lot of the boys would accept camp cookery when they might feel it beneath their dignity to have a course on housewifery. Camp and emergency cooking was tried during the war in one university course, if not more.

Speaker: I think the University of Washington is doing an interesting thing. Every sophomore girl must take one hour a week of food selection and nutrition work. This fall three colleges, for the first time, are requiring the same thing of their students.

Speaker: The reason I asked this question was because in my school work I cannot interest the men of the households that the children come from. I cannot get hold of the men, and they handicap the whole procedure. I feel we should prepare the boys to know how to feed their families and feel the importance of knowing how to take care of them in that respect.

Miss Bears: We do not like to have home economics work defined simply in terms of cooking and sewing. I have heard emphasis placed upon the home, its function as cooperating with the entire school program. In our work we want to think of it as being the study of the family, of the functions of the home as such, and of the part every boy and girl should play in the home. We want to consider the relation of every member of society to every other member and to society as a whole. In our courses for boys as well as for girls we should get it across that each one has a part to play in the family group. If we succeed in the homes of today and the homes of the future, wife and husband may come to be real partners. Every boy and girl should ask in the home, "What am I getting? What am I giving?" If the boys could get that idea in the cooking course they would become more interested in things of the home, their minds and eyes would be opened to fresh interests. I think men do need to have an appreciation of what a home stands for. Too much is left to the woman as being solely in her province. Then, too, women themselves are getting away from the homes, taking part in community, business, or other activities, and there should be cooperation with that in view.

Speaker: What success are you having, where nurses are working in the public schools, in having the child in the parochial schools also supervised?

Miss Bears: The parochial schools are usually taken care of by the Health Department in States where that is done. There are some places where no one takes care of them. Where there is a program under the Health Department they are more apt to have attention.

Speaker: Where Boards of Education are paying school nurses alone, it is hard to get them to allow their nurses to visit in the parochial schools. Our state is carrying out a continuous child health program in 185 communities in the state. The nurses in the school work are under the control of a supervising inspector. The State Department furnishes the technical supervision, and that is the only way we can take any care of the child in the parochial schools.

Speaker: What means have been devised to separate health education from other instruction in the school? The average youngster swears off from June to September—how are you going to hold his interest in health during that long period?

JOINT SESSION: SUMMARIES OF SECTIONS I AND II

Presiding: **TALIAFERRO CLARK, M.D.**, Surgeon, Medical Officer in Charge Field Investigations in Child Hygiene, United States Public Health Service, Washington, D. C.

The Chair: At this meeting we are to have a chance to discuss the papers we have previously heard. I believe the First Section desired some discussion. I am going to call on Dr. Champion.

Dr. Merrill E. Champion, Director, Division of Child Hygiene, Massachusetts Department of Health: Those of us who were at the last meeting recognize that several distinct questions regarding the school child came up which we must face squarely.

The papers by Miss Bears and Dr. Mitchell suggested the question as to what type of examination is going to be given in our public schools in the next ten years. Is there to be a process of weeding out the children who are unfit, or is some process to be worked out in a scientific study?

I am asked that very question by school physicians in Massachusetts. Are they expected under the law to make a careful examination, or are they there merely to see if a child has something wrong and if so send him home or send him to his family physician? I should like to see it the second way. Considering all things I think the most we can do is more or less of a screening process. We need the scientific work, and that is going to be done by the Public Health Service and other agencies—careful, scientific work pointing the way, work which cannot be done under municipal funds.

Are the school nurses going to care for just the school child, or will they find it feasible to include all the children, the children of every age? I do not see how they could do it under the Department of Education. We could not, with our Constitution, in Massachusetts. Some states may be able to, but I think it is the responsibility of the Health Department. If it is, they ought to handle the whole problem.

How is the health program going to affect the scope of the nurse's work? There was a question asked about the percentage of time to be spent in the homes. I myself should have answered that by saying about 15 per cent. She ought not to have to cut off any of the work in the homes.

Then there are the private schools. The private school children are just as much in need of care as the public school children.

The Chair: Is Dr. Snow present?

Dr. Snow, State Normal College, Ypsilanti, Michigan: I come from the State Normal College where we have 2100 girls. We have also a rural school system under our College, which has been very well organized for the last three years. There is a special course for girls who go out and teach in the rural schools, in which we are now able to put a health program. One of the girls in my hygiene class said, "The parents in my locality will not let me put a health program on, and won't let me examine the children. They say they will take care of their children themselves." I gave her a height-weight chart, and told her to tack it up in the school room and say nothing about it at all.

The very first day after she put the chart up, she told me, half the children went and looked at it. At the end of the first week nearly half of them had written down the weight they should be, and at the end of a month every child had been weighed and measured and had come to the teacher with a report. "Are you sure that chart is right?" they demanded. "Yes, thousands of children had been weighed and measured by it," was the answer. "Then what can we do? Do you suppose if we had something right to eat at noon we should be right?" As the children grew more and more interested, the parents began to do so, too, and eventually they organized a parent-teacher association, the children had the right lunches, and now, two years after that first experiment, we are going to have the examinations.

Mr. Ewing: May I raise a point under Dr. Champion's report, regarding the recommendation he makes that if the health of the children is cared for by the school authorities it should not be extended, while on the other hand if it is cared for by the health department it should be. We generally understand that the school authorities are responsible for the health of a child from six years till the time it leaves the school. Many of the children are handicapped in school because of defects acquired before school age. Why is it not the most natural thing that the school authorities should have requirements for admission to school? In many cases the child has to be vaccinated. Why not have physical and mental requirements for first grade and kindergarten? And in that case why would it not be the function of the school physician to examine the pre-school child? In that way we could make the examination a hundred per cent effective because compulsory. If it is done under the Health Department I doubt whether we could make it compulsory. I should think even with the Massachusetts Constitution whatever authority examines them in school age could do it for pre-school age.

Dr. Champion: I am glad of the enquiry. The pre-school child should be looked after. If this were thoroughly done we should not need it for the school age child. I did not want to raise a controversy as to whether it should be the health department of the school department. But why cannot the health department do the thing perfectly? The health department of the future if it is any good at all is going to be responsible for the individual from birth to old age, from nine in the morning to nine next morning. I cannot see the need for this separation which we make so often. I do not think it makes much difference who does it. If you have a strong health department, why not settle it on them? The fact remains that in most places the school department would not have the right to examine a child and prescribe foods for it unless the child were of school age.

The Chair: The whole subject is open for discussion.

Mr. Ewing: I am informed that up to yesterday afternoon as many as two hundred people visited the Children's Bureau in Kansas City. That means there is a widespread interest in this matter of examination of pre-school children. There are comparatively few organizations doing any concentrated work on the subject. It would be helpful I think if those who are undertaking it could exchange literature.

This is the closing session of the Second Annual Meeting of the American Child Health Association. If there is no further discussion, the meeting stands adjourned.

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**JOINT SESSION ON PEDIATRICS AND
OBSTETRICS WITH KANSAS CITY
CLINICAL SOCIETY**

**Causes and Prevention of Antenatal, Intranatal,
Postnatal, and Neonatal Deaths**

**FRED L. ADAIR, M.D., *Associate Professor Ob-
stetrics and Gynecology, University of Minnesota
Medical School, Minneapolis, Minnesota***

Tuberculosis in Infants and Young Children

**RICHARD M. SMITH, M.D., *Assistant Professor
of Child Hygiene, Harvard School of Public
Health, Cambridge, Massachusetts***

Recent Clinical Studies in Urology

**LERoy HUNNER, M.D., *Associate Professor of
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CAUSES AND PREVENTION OF ANTENATAL, INTRANATAL, POSTNATAL, AND NEONATAL DEATHS *

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The value of human life and perhaps that of all life is coming to be more highly appreciated. Individuals have instinctively protected themselves and those dependent upon them from things detrimental to their lives, but only in so far as they could sense the injurious influences which affected them.

After the human being reaches a certain stage he becomes more or less independent and capable of protecting himself from influences detrimental to life and health. Prior to this is a period of absolute dependency upon others for life itself.

This cycle of dependency might be divided into two epochs which are quite different in their requirements for the continued existence of the individual. During the earlier epoch the human being is incapable of leading an independent existence, even with the help of others, except in its peculiar environment. This is the period of intrauterine life. During this stage of development fatalities may occur from some detrimental influence leading to disease and death in utero, or from some factor leading to the expulsion of the fetus from the uterus before it has reached a sufficient development to maintain an existence even with the assistance of others. The fetus may pass the period of viability and die before birth even though its state of development might have permitted a continued, though dependent, extrauterine existence. The offspring may be subjected to influences which cause its death during the process of birth, and these factors may produce this fatal result whether the individual was capable of extrauterine life or not. The infant may be born alive and yet not survive long because of diseased conditions acquired during its intrauterine life, or on account of some harm done the human organism during the process of birth. These infants may also die as the result of diseased conditions acquired after birth.

In this report we are concerned particularly with the causes operating prior to birth which result in intrauterine deaths, and with the factors which cause fatalities during labor. Both of these result in the so-called stillbirths. We are further interested in those conditions

* The carrying on of this work has been made possible through the financial assistance of the Children's Bureau of the Department of Labor, Washington, D. C., of which Miss Grace Abbott is the Chief.

which are acquired during intrauterine life and result in death in early infancy, and also in those affections which are acquired during the process of labor and lead to the death of the infant in its early life. There are also certain diseases which are acquired at or immediately after birth which lead to early fatalities. These various conditions cause the vast bulk of early infant deaths in the first two weeks of life which are spoken of as neonatal or newborn deaths.

After this neonatal or newborn period of two weeks has passed the number of deaths decrease very rapidly and diminish abruptly after the first month of infant life.

Most of the deaths occurring during the first two weeks of infant life are due to causes having their inception during pregnancy, labor, or immediately following birth. The number of deaths due to these causes diminishes rapidly after the first week and especially after the first two weeks of life, though there are a considerable number during the first postnatal month.

This first month after birth is referred to by Ballantyne as the neonatal or period of adaptability. The beginnings and endings of human life are as indefinite and obscure as those of life itself. In the same way it is difficult to fix absolutely and definitely the start or finish of individual human lives, inasmuch as the germ cells are transmitted from one human being to another making a complex continuity of individual human beings. Any effort to trace and locate the effect of detrimental influences on individuals is surrounded with great difficulty. That these harmful factors begin to operate very early in the life of any individual is beyond question. That detrimental influences affect the potential human being even before the ovum is fertilized, cannot, I think, be questioned. We find very definite evidence of disease and malformation beginning in early embryonic life. These conditions may be so serious as to lead to the death of the embryo.

There are two very definite ideas about the origin and manner in which these causes operate. The admirable study of the late Professor F. P. Mall on pathologic embryos, secured from both intrauterine and extrauterine pregnancies, led him to conclude that embryonic and fetal environment was responsible for the diseases, deformity and death which affected these early lives.

Some experimental work of Professor G. C. Huber convinced this fine investigator that some deficiency of the germ cell was the cause of these disastrous results.

Some observations which we have been making of multiple pregnancies lead us to believe that both theories are correct and that anything which has a harmful influence on the germ cell may, if such cell

becomes fertilized, show itself in the development of the embryo and fetus. It also appears that fertilized ova, embryos, and fetuses are subject to conditions which affect their development and imperil their lives even though the original germ cells were quite normal.

When one considers the undetermined and enormous loss of life which results, for the most part, from unknown causes the need for some solution of these problems is apparent.

One needs only to think of the many women desiring motherhood who are disheartened by repeated abortions, usually of improperly developed, diseased or dead embryos. We all grieve with those hopeful, prospective parents who are doomed to disappointment when a fetus is born deformed, diseased, or dead from some influence which affected the germ cells or the growing embryo or fetus, and with those parents who see their living offspring live, perhaps to suffer and die from some malformation, disease, or injury which was acquired during, or possibly even before the period of intrauterine life.

The tremendous importance of study tending to solve these many problems is now coming to be more and more appreciated not only from the standpoint of individual good, but from the viewpoint of community welfare and necessity.

One cannot say, of course, where the most fruitful field for research lies, nor yet which field, when cultivated, will bring forth the greatest yield. There are, however, so many fertile patches that one could hardly fail to bring forth something of great value, if only they are properly cultivated and tended. That certain of these opportunities have not been and are not being seized is, I think, obvious from the citation of certain common statistical facts which not only show the opportunity but also emphasize the need for such investigations.

A tabulation of stillbirths and neonatal deaths (first two weeks of life) occurring in Minneapolis from 1914 to 1923 inclusive shows a total of 3323 stillbirths and 3099 neonatal deaths. This makes a total of 6422 lives lost. One can compare this with the later infant deaths which total 2813 during this same period. By later infant deaths, we mean those infants who died during the first year of their lives, exclusive of the first two weeks.

Another startling fact is that the infant death rate has decreased from 82 in 1914 to 54 in 1923 with 68 as the ten-year rate. The later infant death rate has dropped from 47 to 22 with a ten-year rate of 32.

If one compares the stillbirth rate of 39 in 1914 and 38 in 1923 and the ten-year rate of 38, it is not very encouraging. In the same way one is impressed with the corresponding neonatal death rates of 36, 32, and 35, and also with the combined rates for stillborn and new-

born infants which are 75, 70, and 73. These rates have remained stationary during this ten-year period. Has there been no improvement or is there a lessened rate hidden by more complete and better statistics? One would almost feel that perhaps the more complete returns for births would have been in about the same ratio as the more complete returns for stillbirths and neonatal deaths.

There is another factor to consider, namely, that we are now reporting, as stillbirths and neonatal deaths, infants who have not attained the period of viability.

The question naturally arises as to whether or not we can lessen this enormous loss of life among stillborn and newborn infants. Can they be saved by our present methods of care of mothers and their offspring? Could our present knowledge be used to better advantage? Is there something wrong with our present methods or with their application, and should we change our methods or simply their manner of application?

These questions cannot be answered offhand and unless we are prepared to accept this enormous loss of fetal and infant life as a necessity, we should seek carefully for methods of prevention.

One method of study which is easily applied is that of post-mortem examination of these dead infants. The causes of death can be determined in many, but not all, cases by such investigations, properly done. We can never be in a position to prevent these deaths until we understand their causes.

In order to find out how extensively these autopsies were conducted, we tabulated some statistics for Minneapolis and found that in 1914 there was a total of 13 autopsies done on a total of 595 stillborn and newborn infants. This number increased to a total of 39 in the year 1922. In 1923, about April, we began to make an effort to secure autopsies on these infants and we were successful in securing about 179 during the year. In 1924 up to October first, we have performed about 170, which is about a 30 per cent increase over those secured last year, but only a little over 20 per cent of those which might be secured. It shows, however, what can be done in any community by an effort on the part of those who are interested in studying and solving some of these problems. No one investigator or group of investigators in any community is going to get very far without the stimulation, cooperation, and thought of similar workers in other fields and localities. There will doubtless be local problems as well as universal problems and these will require solutions by methods having both local and general application.

It may be of interest to state in general terms some of the infor-

mation which we have obtained from approximately 240 autopsies performed during a period of about twelve months.

Before taking up an analysis of these cases it might be well to make a few explanatory statements about the terminology used in this report. We use the terms antepartum and antenatal as synonymous as to the time when a stillbirth occurred with relation to labor. In the same manner we use the words intrapartum or intranatal, as also the terms postpartum or postnatal stillbirths, as applied to these fetal deaths which are included under the general and commonly used expression of stillbirth.

The use of the word neonatal or newborn applied to infant as distinguished from fetal death is in this report limited to those deaths occurring within the first two weeks of infant life. We have not included the postmortem examination of infants beyond this period of life as most of the problems in which we are primarily interested fall within this period.

Those fetal deaths which are included under the name antepartum or antenatal stillbirth are those which occur, according to the best evidence available, either clinical or pathological, prior to the onset of labor.

We realize fully that there are many intrauterine antepartum deaths which occur prior to the period of viability. These we may divide into embryonic deaths as distinguished from those of the fetus and the previable fetal deaths.

The intrapartum fetal deaths or intranatal stillbirths are those fatalities which occur during the process of labor itself, no matter whether the labor was spontaneous or artificial in its onset.

The postpartum or postnatal stillbirths are those occurring a short time after the birth in fetuses in whom the heart continues beating for varying lengths of time without the establishment of respiration.

With the establishment of respiration, however poor it may be, we consider the neonatal period to have begun. Any death prior to this we consider to be a fetal death or a stillbirth, falling into one of the groups mentioned above.

NONVIALE FETUSES

We have a series of about nineteen autopsies which have been performed on nonviable fetuses. These fatalities are reportable as stillbirths to the Health Department of our community.

In these cases the body length, weight, and menstrual age indicate that the fetuses had not reached the period of viability. The menstrual

age was in each instance less than 24 weeks, and the crown-heel length was under 34 cm. We consider the body length to be better evidence of fetal age than the body weight, especially in dead fetuses.

Three fetuses in this group died postpartum stillbirths and two of these deaths were of twin fetuses.

There were six intrapartum or intranatal stillbirths and ten antepartum or antenatal fetal deaths.

ANTENATAL STILLBIRTHS

We have a relatively large group of antenatal fetal deaths, over one-fifth of the entire series, 51 cases in actual numbers.

Of these, twelve occurred in fetuses born at term and 39 in those fetuses which were prematurely born. If reduced to percentage, it gives the deaths at term 23 per cent and premature fetuses 77 per cent.

Fetal malformations accounted for two of these deaths, one an anencephalic monster and the other from congenital cystic kidneys. Both of these were premature infants.

Maternal toxemia was responsible for twelve of these fetal deaths, in two of which there was associated partial or complete detachment of the placenta.

Syphilis was responsible for nine of these fatalities among premature antenatal fetal cases, and was the probable cause in two others.

Premature rupture of the membranes and premature onset of labor from traumatic and accidental causes brought about the fetal death in four instances.

Maternal infection caused two fetal deaths.

Placenta prævia caused one death, and the cause could not be determined in six cases.

The big factors in causing antepartum deaths in premature infants are toxemia of pregnancy, which caused approximately 35 per cent, syphilis, which can be charged with about 30 per cent, undetermined causes in about 15 per cent, and accidental causes in nearly 15 per cent.

The causes of the antenatal deaths of term fetuses were not so easy to determine, strange as that may seem. We were unable to find satisfactory cause in eight of the twelve cases, or about 65 per cent. Lues was evident in two, or about 17 per cent. There was one extra-uterine pregnancy at term.

INTRAPARTUM STILLBIRTHS

In all there are 39 cases in this group, or about one-sixth of the entire series. Fifteen of these are prematures and 24 term fetuses.

Toxemia of pregnancy with induction of labor, artificial delivery, is held responsible for five deaths among these premature offspring.

Four cases had a premature onset of labor, usually with a rapid or precipitate delivery and evidence of intracranial or other birth injury.

Placenta prævia with induction of labor and artificial delivery plus birth trauma caused the death of three, and syphilis escapes responsibility except in one instance.

Malformations of major degree were present in three of these cases, in one of which toxemia was also present.

Definite evidence of severe intracranial birth trauma was present in eight of these fifteen cases, which is over 60 per cent.

There were 24 term cases, among which there were seven breech deliveries, one of which had a major malformation. They all showed definite findings indicative of serious intracranial injury.

There were ten instances of dystocia with the use of pituitrin, forceps, version, and craniotomy, all of which gave evidence of serious birth trauma to the head and in one case to the cervical spine.

Placenta prævia and placental detachment account for two fatalities.

Maternal toxemia occurred three times and is responsible at least indirectly for these casualties.

In all there were four of these fetuses which suffered major malformations, but the most important point which I wish to drive home is that 17 of the 24 had very definite evidence of serious birth trauma; these were generally intracranial as evidenced by tears and hemorrhages of the dural folds and other intracranial hemorrhages.

POSTNATAL STILLBIRTHS

We have examined by autopsy about 36 of these fetuses, of which 20 were premature and 16 at term.

There were nine major malformations. Five deaths were caused by birth trauma among these premature infants.

Atelectasis and evidence of death from suffocation account for the remaining six cases of death.

The premature labors and deliveries were all spontaneous with cephalic presentations in all except three breech positions.

There were four major malformations among the 16 postpartum term stillbirths which were incompatible with extrauterine existence.

Intracranial birth injury was present in all of the remaining twelve cases at term. The delivery was spontaneous in nine instances with one breech and eight vertex presentations. Podalic version was done four times and forceps operations were performed twice and breech extraction was necessary once.

NEONATAL DEATHS

In our series of post mortem examinations there was a total of 92 neonatal deaths. Of these 55 or about 60 per cent were in premature infants, and 37 or about 40 per cent among full term babies.

Of the prematures, 35 or over 60 per cent died within the first day.

There were two of these labors induced because of pregnancy toxemia. One Cæsarean section was performed, one forceps operation, and one podalic version were done. The presentations were vertex in 26, breech in eight, and shoulder in one. With the exceptions noted above the deliveries were spontaneous and some were precipitate.

Intracranial injury as evidenced by tears and hemorrhage was found in 16 instances or nearly 50 per cent of the cases.

Exposure caused three deaths, syphilis was responsible for two, and peritonitis for one fatality. Atelectasis was present in varying degree in over 95 per cent. Small visceral hemorrhages were present in over 70 per cent with a dilated and engorged right heart in 80 to 90 per cent. This indicates a cardio-respiratory death in the vast majority of the cases back of which probably lies some brain insult.

The premature onset of labor was without apparent cause in fourteen, or more than 50 per cent, of these deaths of prematures on the first day.

The later deaths among the prematures were scattered one to three per day up to the eleventh day. There were twenty of these deaths in all.

Most of these cases had an unexplained onset of labor, though it was induced twice because of toxemia. Forceps were used twice and there were two breech deliveries. The remainder of the labors ended spontaneously. Eight cases showed intracranial injury and three of them lived until the sixth, ninth, and tenth days when other conditions caused or contributed to their deaths.

Congenital heart disease accounted for two deaths. Infections caused seven deaths beginning with the fourth day.

Icterus was commonly present, being noted in sixteen of the twenty cases.

Hemorrhagic disease seems to have been responsible for one death and starvation for another.

Birth trauma in the earlier days and infections after the fourth day seem to be the more frequent causes of death in this group.

Altogether there were thirty-seven deaths of full term infants, of which thirteen occurred on the first day.

There were two breech and one face presentation. There were

two forceps deliveries. The remaining labors were spontaneous, and some were precipitate. Pituitrin was used in at least one instance.

Intracranial injury was present in nine cases. There were three major malformations.

The other twenty-four term infants died on different days up to the thirteenth. An examination of the head was not permitted in five of these cases, but evidence of injury to the brain or membranes was found in seven of those examined. There was no major malformation. There was possibly hemorrhagic disease in four of the cases. There was one case of melena which originated from a duodenal ulcer. Various types of infection seemed to be responsible for death in seven instances. The earliest death from infection took place on the sixth day.

SUMMARY AND CONCLUSIONS

1. It is important to realize that there has been little if any reduction in the frequency of stillbirths and neonatal deaths for many years past.

2. The causes of this mortality are not thoroughly nor generally understood.

3. One method of investigation is open to investigators in nearly any community and it should be utilized; I refer to the method of post mortem examination.

4. There is no more fruitful field for pathologic research than that comprised in the domain of gross and microscopic study of fetuses and newborn infants.

5. It is by this and other methods of study that we may hope to ultimately reduce the number of these fatalities.

6. We must reduce the number of premature births by better care of women especially during pregnancy.

7. The only way of saving the lives of the nonviable group of fetuses is by prolonging the period of gestation by properly understanding and preventing the causes of the premature onset of labor.

8. Antenatal stillbirths make up a large group, nearly one-fifth of our series. The main factors contributing to these fatalities are toxemia of pregnancy, syphilis, and undetermined causes.

9. The intrapartum stillbirths make up about one-sixth of all our cases. Over half the prematures and three-fourths of the term infants suffered severe birth injury as the result of spontaneous labor or of various procedures instituted for a variety of conditions.

10. The group of postnatal stillbirths includes a considerable number of major malformations. About one-half of these postnatal fatalities may be said to be caused by birth trauma.

11. Among the neonatal group, birth trauma causes most of the deaths which occur during the early days of postnatal life, probably about 50 per cent. Infection plays a very prominent rôle after the fourth day of life.

12. We do not find that hemorrhagic disease plays so important a part as it is considered by some to have in the causation of fetal and early infant deaths.

13. We are of the opinion that toxemias of pregnancy, birth trauma, undetermined causes, syphilis, and other infections are the main factors entering into the etiology of these deaths.

14. The main measures of protection of the infants and the prevention of the fatalities are in the light of our present knowledge: (a) the early detection and management of the toxemias of pregnancy, (b) the prevention, diagnosis, and control of syphilis, (c) the reduction and prevention of birth injuries by better obstetric practice, (d) the prevention of premature births and the better care of premature infants, (e) the better care of newborn infants to prevent exposure, improper feeding, shock, and infection.

15. In short, it is imperative that prospective mothers ask and receive more and better antenatal, intranatal, and postnatal care for both themselves and their offspring.

CLINICAL ASPECTS OF TUBERCULOSIS IN INFANTS

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At the Infants' Hospital, Boston, from May 1 to September 1, 1924, a diagnosis of tuberculosis was made in 9.4 per cent of the admissions. During this same period 28.3 per cent of the deaths were due to tuberculosis. Stating it in another way one child out of every ten admitted had tuberculosis and this disease was the cause of more than one out of every four deaths. This incidence of deaths is somewhat greater than in the two hundred consecutive autopsies reported in 1922 from the same hospital by Lawrence W. Smith in which tuberculosis was present in 20 per cent of the cases, and higher than in 1328 consecutive autopsies at the Babies' Hospital in New York reported by Wollstein and Bartlett where the percentage of tuberculosis was 13.5 per cent.

It is not my purpose to discuss the mode of infection, the primary focus or the portal of entry. In this connection I wish simply to call attention to the fact that tuberculosis in infants and young children is contracted from one of two sources: from milk or from human beings. In six consecutive admissions of children with tuberculosis to the Infants' Hospital during July, five had received cow's raw milk, and there was no known contact with active cases of the disease in human beings. This is an unusually high percentage of milk-borne infections if all these infants contracted the disease from this source. In general the bovine type of tubercle bacilli is responsible for not over 25 per cent of the cases. A much higher percentage of bovine infection occurs in special locations. Cervical gland tuberculosis and mesentery gland infection with or without extension to the meninges are due in a large percentage of instances to the bovine tubercle bacilli while lesions confined exclusively to the lungs are rarely of this type.

Raw milk still is used for infant feeding, even when no measures have been taken to insure its freedom from active tubercle bacilli. The fear of destroying vitamins by boiling or pasteurizing milk is the cause of many deaths from tuberculosis. The only raw milk which it is ever safe to use is that from a herd which has been proved by repeated tuberculin tests to be free from tuberculosis. Only the most rigid supervision such as is given to certified milk meets these requirements. The certification is as valuable as the conscientiousness of the members of the commission. Recently in a city in Massachusetts a certified herd

was found to have a large percentage of tuberculous animals. Unfortunately this discovery was not made until several children had contracted the disease and one had died. It seems trite even to mention these obvious matters, yet our experience indicates that there still is need of much education in this particular, not only among the laity, but also among physicians. Until this education has produced results, we shall continue to see our hospital wards filled with infants ill and dying from infection with bovine tuberculosis. It is to be remembered that products made from milk—butter, ice cream, cheese—require the same protection as milk itself.

Two sisters were admitted recently to the hospital with active and subsequently fatal tuberculosis. Their mother had been allowed to return home from a tuberculosis sanitarium with a known active process in her lungs and tubercle bacilli in her sputum. It has been shown repeatedly that two out of every three children intimately exposed to active tuberculosis will contract the disease. Whatever one's ideas may be as to the care of adult patients with tuberculosis, it can be said definitely that they must be separated from children. Until this fact is given universal recognition and action is based upon it, we cannot hope to see human tuberculosis eradicated or the deaths from tuberculosis materially decreased.

There is little new information about tuberculosis but the disease is of such frequency and importance that certain facts with reference to its clinical manifestations will bear repetition. Despite our long contact with this infection, we are slow to appreciate some fundamental considerations. Since our only hope of successfully combating the disease lies in the adoption of proper measures of prevention and early diagnosis, it is necessary for us to know accurately its essential characteristics.

Infants and young children with tuberculosis may be divided into two groups in which the manifestations of the disease differ widely in physical signs, prognosis and treatment. One group includes infants with a local infection and the other group those with a general infection. The local process may not be necessarily at the portal of entry of infection into the body, but is the seat of present activity. It is confined in the majority of instances to the bones, to the glands, or to the peritoneal cavity. The skin and other tissues are less frequently involved.

Tuberculosis of the bones may be in the joints, the spine, the metacarpals, or in the form of tuberculous osteomyelitis. The course of such an infection is long. The treatment consists of rest of the infected part with or without operation and of general hygienic measures.

Glandular tuberculosis is most common in the cervical glands. The

enlargement of the glands may occur rapidly and is not infrequently associated with an acute infection of the tonsils with some other organisms, most often a streptococcus. The swelling may be gradual in development. A high percentage of enlarged cervical glands are infected with tubercle bacilli. Unless the swelling quickly subsides, it is fair to assume tuberculous infection. It is extremely difficult when the enlargement has become chronic to determine whether or not the glands are caseous. Softening is deep and the overlying tissues firm so that fluctuation may be absent. It is advisable in every instance of enlarged cervical glands to remove the tonsils and adenoids as soon as the evidences of the acute pyogenic infection have disappeared. General hygienic treatment may be given for a period of weeks with the possibility that the glands may subside. If at the end of such a period the swelling is still present dissection of the glands should be done. If a child is seen after the swelling of the glands has been present for weeks or months, it may be advisable to remove the tonsils and dissect the glands at the same time. This certainly should be done if there is any suspicion that the glands are beginning to break down. I am strongly opposed to the practice of allowing this condition to progress until one gland after another softens—opening and draining one gland at a time. This prolongs the period of surgical treatment for many months, often two or three years, and leaves behind badly disfiguring scars. The radical operation requires excellent technique to avoid injury to the nerves and blood vessels and possible paralysis, but when properly done produces excellent immediate results and a very slight scar.

Mesentery gland tuberculosis is hard to diagnose. Its course is usually chronic, and, except in a few instances, the treatment is general and not local. In certain instances where it is possible to feel a mass of enlarged glands, these may be removed by operation. This hastens recovery and also prevents an extension of the infection to other parts of the body.

Bronchial gland tuberculosis should be carefully distinguished from chronic infection of the bronchial glands with other organisms. The signs of enlarged bronchial glands are too well known to require enumeration at this time. If there is an active tuberculous infection in the bronchial glands, it is almost always accompanied by, or is a part of a process at the hilus of the lung. Treatment is directed toward increasing the resistance of the individual child.

Tuberculosis of the peritoneum may be confined exclusively to that portion of the body, but not infrequently it is a part of a general infection. It is important in every instance to look for evidence of infection

in other parts of the body, especially in the lungs. When any signs of tuberculosis can be found elsewhere, the prognosis becomes immediately that of a generalized process. The condition in the peritoneal cavity is not altered so far as the local manifestations are concerned. The two types of the disease—one with fluid and the other dry or the plastic type—are well known. Abdominal distention is often the first sign to be noticed, accompanied with loss of weight and a poor general condition. The diagnosis is often made at the time of an operation done for the removal of a supposedly acute infected appendix. Obstruction is sometimes present early and usually develops at some period of the disease, especially in the plastic type. The prognosis is bad, but not hopeless in children under two years of age, provided there is no extension beyond the peritoneum. The outlook becomes more favorable as the children get older. I am convinced that the greatest benefit is derived from general measures rather than from surgical intervention. If there is a large accumulation of fluid, it should be removed, or if obstruction is present, it must be relieved. Fecal fistulæ are common sequelæ from such procedures. Heliotherapy is of immense value in promoting the healing of the local infection and in improving the patient's general condition.

In the diagnosis of localized tuberculosis, the tuberculin reaction is of great value. Indeed, it is essential. The intradermal test is to be preferred to the von Pirquet test. It is much more sensitive and as easy to interpret and has no disadvantages, except the slightly greater difficulty of application. It is customary to use 0.01 mg. of tuberculin in salt solution. If the reaction to this amount is negative, the dose may be increased to 0.1 mg. A positive or negative reaction in infants is a reliable index of the presence or absence of tuberculosis. Frequently this is the only definite finding. The physical signs of the disease may be too slight to be demonstrable.

When tuberculosis in infants ceases to be a local process and extends to other parts of the body, it becomes in general a septicæmia. One speaks of tuberculosis of the lungs, or tuberculous meningitis as though they were separate diseases. This is rarely the case in infants and young children. It is possible that during life, signs sufficient for recognition may be present in only one organ or system, but at autopsy the infection is found to be widespread. This is almost universally true when there are signs of meningeal involvement or when the lungs show a process beyond the hylus. The generalized infection may develop under observation by extension from a known local lesion or may be widespread in distribution when the patient first comes under our care. The latter alternative is the more common. Because of the fact that the

lesions in tuberculosis are so extensive, the prognosis is entirely bad. Very few children under two years of age with a general infection survive. If the meninges are involved, the outcome is invariably fatal.

General tuberculosis is frequently as difficult to diagnose as a concealed local process. It should always be borne in mind as a possibility in any child who presents evidence of unsatisfactory progress in growth and development, or in one who is running a persistent temperature, or who is complaining of unusual fatigue. The physical signs of widespread tuberculosis are for the most part in the lungs, the meninges, or the peritoneal cavity. The spleen is usually palpable after the process has gone on for any considerable period of time. Tuberculides are not common in our experience and it is often difficult to be sure of their diagnosis. They may be present in great numbers and are an evidence of active and widespread infection. Tubercle bacilli are found sometimes in the urine. They indicate that there is a lesion in the kidney. Acid-fast bacilli in the urine should not be considered tubercle bacilli until proved by culture or guinea pig inoculation. At the onset of infection the physical signs in any part of the body may be slight, even though the pathological process is well established and extensive lesions are present. The general condition of the infant may be fairly good—the nutrition well maintained and the temperature slight. As the disease progresses this ceases to be true and the important evidences of the infection become manifest.

In the lungs it is often difficult to differentiate a consolidation due to tubercle bacilli and one due to other organisms. It may be impossible to determine this except by a prolonged period of observation and study of the course of the disease. The signs are usually those of a bronchopneumonia and do not involve all of any single lobe. This is not always the case. Occasionally one finds the process limited largely to one lobe and in this event cavity formation may occur. This is the adult form of tuberculosis and is rare in infants. The usual lesion is a diffuse one extending outward from the hilus involving all or portions of both lungs with or without the scattered areas of bronchopneumonia. The physical signs of such an infection when no bronchopneumonia is present consist only in increased intrascapular dullness extending toward the apices, usually with evidence of enlarged bronchial glands. In miliary tuberculosis both lungs are filled with minute patches of consolidation, but it is often impossible to discover these on physical examination. Sometimes the lungs seem entirely clear, at other times fine crepitant râles can be heard everywhere throughout the chest. The X-ray is of great assistance in furnishing supplementary evidence. Negative findings are of particular importance. Positive findings must

be interpreted in connection with the signs detected on physical examination and in the light of the other features in the history of the individual child. If the areas of increased density extending outward from the hylus involve the middle third of half the chest, especially if there is an impairment of the apices, tuberculosis should be strongly suspected. This suspicion is strengthened if, in addition, the glands are enlarged and especially if some of them are calcified. Occasionally there is an extensive involvement of the bronchial glands so that the entire upper portion of the chest is filled with a mass of enlarged glands in various stages of infection. The pressure of these glands on the trachea may be sufficient to cause embarrassment to respiration. When the glands break down, erosion into the trachea may take place with the discharge of caseous material.

Tuberculosis of the meninges may show very slight evidence of meningeal infection. Extreme irritability, an occasional sharp high-pitched cry in an infant who is not making satisfactory gains in weight may be the only symptoms to attract attention. The physical signs of meningitis may be entirely absent—sometimes there is a little resistance to flexion of the neck. The examination may make the infant cry out as if in pain. Sometimes the rigidity and retraction of the neck with Kernig and Babinski signs are present early. There is usually a great variation in the signs from day to day or even from hour to hour. In all suspicious cases a lumbar puncture should be done and in our experience tubercle bacilli can be demonstrated in the spinal fluid in practically every instance if careful search is made, particularly if the pellicle, which forms after the fluid has stood for a few hours, is examined. The outcome of the disease when the meninges show signs of involvement is always fatal. The course is often slow, convulsions are frequent and unconsciousness usually develops, making it necessary to supply nourishment by gavage. In occasional instances the disease runs its entire course from the first symptom to death within a few days.

CONCLUSION

Tuberculosis is a common disease in infants.

A diagnosis of tuberculosis should be considered in every infant who is not making satisfactory progress in development.

Tuberculosis in infants can be materially reduced by never giving them raw milk unless it is certified and by keeping them separated from active or open cases of human disease.

From the standpoint of the clinician, tuberculosis in infants is a local or general disease.

Local tuberculosis is commonest in the bones where special treatment is needed, in the cervical glands where a radical surgery should be employed, and in bronchial and mesentery glands and the peritoneum where general hygienic measures and heliotherapy are indicated.

General tuberculosis may show during life signs predominating in or confined to one part of the body but at autopsy lesions are found in meninges, lungs, spleen, liver, glands and elsewhere. The prognosis in infants under two years of age is almost invariably hopeless.

The intradermal test and the X-ray are valuable and reliable aids in diagnosis.

RECENT CLINICAL STUDIES IN UROLOGY

GUY L. HUNNER, M.D., Associate Professor in Clinical Gynecology, Johns Hopkins University Medical Department

It gives me great pleasure to bring before you the results of special clinical researches extending somewhat intensively over a period of ten years. A western man by birth and early schooling, I am counting on the open mind characteristic of this region, to grant me a sympathetic hearing, although I may bring some ideas that challenge your credulity because they are out of conformity with your previous training and beliefs. It may seem an anomaly for a man trained in Gynecology to essay to bring before you the results of work in Urology. In extenuation I may plead that it has been my good fortune to have my early medical training, and to this day a close association with that great clinician, Dr. Howard A. Kelly, whose genius not only placed American Gynecology on a firm foundation, but contributed in a remarkable degree to our present day knowledge of urology.

It is but natural that one of his students should champion the idea that in subdividing medicine into specialties one logical division is that which combines gynecology with female urology. Viewing the close association in the developmental and anatomical relations of the generative and urinary tracts one is not surprised that the diseases of these two systems of organs are frequently associated, and that disease confined to one of these tracts is often erroneously diagnosed and treated as disease of the other.

In dealing with the male it has seemed a natural development for the physician specializing in the diseases of the genital tract to take the leadership in the modern development of urology; but for the most part this close association of the two systems of organs has not been followed by those dealing with the diseases of women.

If the gynecologist does not wish to burden himself with the exacting demands of the urological field he should at least be closely associated with a competent urologist, and if the urologist has not been well trained in gynecology, he cannot do justice to his women patients without frequent consultation with the gynecologist.

It is my purpose to bring to your consideration theories and facts concerning a disease, the importance of which is just beginning to be recognized. I believe you will all agree with the statement that the remarkable progress of modern urology has made of this specialty one of the most accurate and scientific branches of medicine; but if I add

to this the statement that the urologist in spite of his rapid progress has been consistently overlooking the most important lesion in the urinary tract, I am certain that enough of you are "from Missouri" to demand that you "be shown" substantial evidence for such a startling claim. The conception of ureteral stricture as an important disease entity has sufficient newness for most of you to make you feel that here is a technical subject for a narrow band of specialists, and if you were only well out of the audience you could spend a more profitable hour at the movies.

I hope, however, to demonstrate that any physician or surgeon who is interested in abdominal and pelvic diagnosis must, if he hopes to do justice to his patients, familiarize himself with the multifarious phases of ureteral stricture. The orthopedist in making a diagnosis will eventually recognize the close relationship of this disease to his specialty. The roentgenologist will be particularly interested in what I have to say and to demonstrate on the screen. Ureteral stricture, being mostly of focal infection origin, the otolaryngologist and the dentist will appreciate the added importance and dignity which recognition of this disease confers on their specialties.

Are there any other specialists in the audience whom, through failure to mention I have promised to neglect? Yes, there is the internist who can rightfully claim the distinction of being the broad based inquisitor in all the ills of the human frame, and the neurologist who is interested in ferreting out the intricate manifestations of the soul and mind life and their relationships and reactions to the physical body and its environment. I hope to remind these specialists that not a few of their patients, who are being treated to "rest cures" and mind cures have as a basis for their social incoordination a real organic disease, the proper treatment of which would do away with considerable mal-directed therapeutics.

Now let us depart from this too lengthy introduction before you accuse me of bombast or of attempting more than can be demonstrated, and get down to a few facts that have developed in a study of more than 2500 cases diagnosed as ureteral stricture in the past ten years.

Much of what I have to say is already familiar to the urologists and they will have to bear with me for a restatement of claims familiar to them because this is primarily a general audience. Many of my lantern illustrations have never been published and these at least will be of interest to the urologist.

Ureteral stricture is one of the most common lesions of the abdomino-pelvic cavity. The symptoms due to ureteral stricture lead

to more errors in diagnosis, and to more ill-directed therapeutics and unnecessary operations than do those of any other disease.

The operations performed because of symptoms due to ureteral stricture are in about the order of their frequency as follows: appendectomy, oöphorectomy, gall-bladder operations, various kidney operations, suspension of the uterus, and other pelvic operations on the outlet and perineum. Some patients run the gamut of all these operations, and subsequent surgeons, having no unattacked organ on which to blame the persisting symptoms, then explore the abdomen for adhesions supposedly left by their forerunners.

In its rôle as an imitator of other abdominal and pelvic disorders ureteral stricture is one of the important diseases of the abdomen. This is because of its frequency, its direct influence on the health of the patient, and because of the indirect morbidity to which it leads through faulty diagnosis and therapeutics.

Of far more importance, however, is its purely urological aspect. Considered merely as a cause of bladder distress it ranks high, and if it had no other rôle the urologist could ill afford to ignore it.

When the urologist begins to realize what ureteral stricture means as a cause of renal pathology, he will accept my statement that he has been overlooking the most important lesion of the urinary tract.

Some of the conditions in which ureteral stricture is often found as an associated lesion and in which it is only reasonable to suppose that the stasis caused by stricture is one of the chief causes of the pathology, are as follows: hydronephrosis, sterile and infected; pyelitis, of the chronic form which eventually reaches the urologist for treatment; pyonephrosis; many cases of pyelitis of pregnancy and of the puerperium; many cases of multiple abortion due to renal incompetence; some cases of pyelitis in children; essential or idiopathic hematuria; ureteral and renal calculus; some cases of chronic nephritis heretofore considered as purely medical; most cases of congenital malformation which develop renal pathology and seek the urologist.

This is certainly a formidable list of renal pathological conditions and in the limited time at our disposal, I can only show you the radiographic evidence of some form of obstruction existing in the ureter in patients who present clinical evidences of these conditions. In numerous previous publications I have gone into more detail concerning the relative value of pyelography and the use of a bulb in the diagnosis of stricture. I have also dealt with the results which one may expect from treating these diseases by the simple expedient of dilatation to restore good drainage. I have shown that ureteral stricture is usually of focal infection origin and that successful treatment often demands

attention to distant foci of infection, most often located in the tonsils, teeth, and sinuses.

We are just beginning to realize what the early recognition and proper treatment of ureteral stricture will mean to the patient in the saving of unnecessary kidney operations. Our present day literature shows that most surgeons are still attacking the secondary pathology in the kidney instead of dealing with the primary lesion in the ureter. A partial list of such needless operations includes the following: (1) nephropexies for ptosed kidney, hydronephrosis, and the so-called "kinks" which are usually misinterpretations of the X-ray view of the dilated, ptosed upper ureter with its extra wide, freely draining lumen; (2) direct attack on the kidney for drainage in infections, which can usually be cleared up by establishing good ureteral drainage; (3) nephropexies, nephrotomies, decapsulations, and nephrectomies for the so-called essential hematurias; (4) all the above operations for similar pathology, occurring in kidneys of congenital malformation, the pathology most often being due to ureteral stricture and amenable to non-surgical methods of treatment; (5) multiple operations for recurring ureteral and kidney calculi, the recurrences being due to the neglect to establish proper ureteral drainage before or in connection with the original operation; (6) nephropexies, decapsulations, and nephrectomies for nephralgia; (7) the latest fad in kidney surgery, that of sympathectomy. Fortunately, the virus has not yet "taken" seriously in America. Quoting from the latest report at hand ("Resection of the Nerves of the Kidney for Nephralgia and Small Hydronephroses." Papin and Ambard, *The Journal of Urology*, April, 1924, XI, p. 337), "interesting results can obtain from resection of the nerves in painful nephritides, small hydronephroses and nephralgias not having a well established etiology. These have been treated hitherto in a rather unsatisfactory manner. Decapsulation, temporary nephrotomy, nephropexy have been insufficient, while nephrectomy is too radical.

"There is no more difficult problem to solve than that of small, painful hydronephroses. To such a patient we can only offer nephrectomy of the almost normal kidney."

Fortunately we now know that ureteral stricture is the chief cause of "small painful hydronephroses," and it is unquestionably the greatest factor leading to renal conditions resulting in nephralgia.

We can quite agree with Papin and Ambard in their statement that "renal pain is usually a renal pelvic pain and if one excludes the rare cases of torsion of the pedicle, colic usually means a distension of the pelvis."

That they are dealing with unrecognized ureteral stricture cases

is suggested by many features of their report. Their case histories are typical of those associated with stricture, including in some the bladder disturbances so often present. Most of their patients were found by preliminary investigations or at operation to have a slight hydronephrosis, and the most striking evidence that they are dealing with ureteral stricture, unrecognized, is their statement that, "the most important area in the ureter is the one which can be felt through the rectum or vagina (the inferior ureteral). It often causes when touched most severe reflex pains in the kidney." Every physician who, as a part of his routine examination, systematically palpates the ureter at the pelvic brim crossing and in the broad ligament regions, should know that such hypersensitiveness generally means an inflammatory process in the ureter. Do you wonder, therefore, that I sound a warning to American surgeons, who are prone to adopt new operations, to allow this operation of sympathectomy for nephralgia to be tried out in the country of its origin until it proves wanting and finds an early grave.

Because of the insidious onset and latency of symptoms in many cases of stricture there will always be the necessity for some operations for the above described renal diseases.

Under certain conditions, either anatomical or acquired, the upper ureter may remain more or less fixed, while a hydronephrotic kidney begins a descensus or rotation, resulting in an actual kink between pelvis and ureter or in a valve-like action when the enlarged pelvis becomes full. Inflammatory processes within the kidney, such as a pyelitis, an infected hydronephrosis, a pyonephrosis, or an infected calculous kidney may set up perirenal or periureteral processes resulting in mechanical obstruction to the outflow of the urine. In such cases it may be difficult or impossible to overcome this secondary area of obstruction by cystoscopic means, and while the dilatation of the lower primary lesion in the ureter may result in great improvement in the patient's symptoms, operation may become necessary. Such operation, however, is accessory to the preliminary cystoscopic work on the lower ureter and the operation is far more likely to result successfully because of the preliminary ureteral work.

Before turning to our lantern slides for a partial verification of the above thesis, I wish to appeal to every physician present not to look upon ureteral stricture as a new disease, of rare occurrence, and of intricate diagnostic features soluble only by the specialist. It is a disease of common occurrence which should have a tentative diagnosis established by the general practitioner, unaided by the specialist, in

as large a proportion of cases, and with as much certainty, as obtains in chronic cholecystitis or chronic appendicitis.

The three chief complaints are (1) pains in the area of the local disease usually situated in the lower ureter, (2) backache, pain in the flank, and kidney colic from the urinary stasis, and (3) bladder disturbances often of an intermittent character. I will elucidate these and the innumerable other symptoms which may arise from ureteral stricture as we review some of the case histories suggested by the lantern slides.

[NOTE: In an early issue of the "*Urologic and Cutaneous Review*" this paper will appear in full with reproductions of these lantern slides.]



AMERICAN CHILD HEALTH ASSOCIATION

REPORTS OF AFFILIATED SOCIETIES

For the Year Ending September 30, 1924

**UNITED STATES, CANADA, MEXICO,
CZECHOSLOVAKIA, POLAND, CHINA**

REPORTS OF AFFILIATED SOCIETIES

CALIFORNIA

Berkeley

BERKELEY HEALTH CENTER, INC.

Organized 1906.

Aim: To provide free medical care to the people of Berkeley who are unable to pay a doctor. To provide preventive and educational health service to anyone, regardless of financial status. To provide public health nursing in the homes.

Board: There are 25 men and women on the governing board.

Territory: An urban population of 65,000 is served.

Staff: Medical Director, Superintendent of Institutional Service (R.N.), 3 assistants (registered nurses) one of whom is a resident nurse who takes night calls and cares for night clinics. Superintendent of Social Service (graduate of University of California, A.B.), 1 full-time assistant (graduate of University of California, A.B.), 1 full-time clerical assistant. Office manager, 1 half-time assistant. Superintendent of Field Staff, 8 supervisors (public health nurses). University of California Public Health Nursing Class, who spend 3 hours per morning in field work. Full-time dentist. Dental Hygienist. Physiotherapist (part-time). Anesthetist (part-time).

Type of work: Preventive and curative.

Financial: The budget for the current year is \$35,000. Funds are derived from the City of Berkeley, the Community Chest of Berkeley, and the County of Alameda.

General statement: No restriction is made regarding race, color, creed or age in the services. Intensive medical social case work is done for each case requiring it. If people needing care are not ambulant, a worker is sent into the home. Close cooperation is secured with all relief and health agencies in the city and county, which prevents duplication. Doctors give their services with the exception of the well baby conference, for which a fee of \$5 is paid, the venereal clinician and a paid anesthetist.

DEPARTMENT OF HYGIENE, UNIVERSITY OF CALIFORNIA

Organized 1907.

Type of work: Educational.

Long Beach

LONG BEACH DAY NURSERY

Organized November 1, 1912.

Aim: Organized for the purpose of assisting working widows and deserted mothers, also widowers of small means, to keep a home for their children.

Board: The governing board consists of 15 women.

Territory: The nursery serves an urban territory, which has a population of 135,000.

Staff: Superintendent of the nursery, who is also supervisor of social service and nutrition work, 1 nurse, 2 doctors serving part-time, 1 teacher for part-time and 1 housekeeper.

Type of work: A day nursery which receives boys from one to ten and girls from one to thirteen years of age. The homes are visited, classes are held for pre-school and school children. The children act as group leaders and help with games and in the kindergarten.

Financial: Supported by membership dues and Community Chest.

General statement: The mothers' club organized over a year ago, has taken charge of the entertainments and summer outings during the past year and a very fine spirit of cooperation has been stimulated among the members. Efficient committees to call on new mothers and ill mothers.

Los Angeles

MOTHERS' EDUCATIONAL CENTER

Organized 1916.

Aim: Prenatal education in child care and training. To insure children their right to the fullest development, mentally, morally and physically.

Board: Governing board consists of 14 members.

Territory: The organization serves an urban and rural territory including 5 counties.

Staff: (Paid), Director, medical examiner. Office clerk. (Volunteer) lecturers, 7. Teachers, 6. Doctors, 10. Nurses, 3. Social workers, 4. Day committee, 22.

Type of work: Preventive, educational.

Financial: Budget, \$8,000. The center is supported by the Chamber of Commerce and membership fees.

General statement: Total number of mothers instructed 1923, 10,944, an increase of 3,117 over previous year. Number instructed through lectures and classes, 6,434, in special problems, 4,510. Divisions include character building and conduct, nutrition, posture and growth handicaps, conservation of vision and prenatal instruction.

Oakland

ALAMEDA COUNTY TUBERCULOSIS ASSOCIATION

Organized December, 1908.

Aim: Study, prevention and relief of tuberculosis.

Board: Governing board consists of 19 men and 7 women.

Territory: The Association serves an urban territory with a population of 410,000.

Staff: Executive secretary, 2 clerical assistants, tuberculosis nurse, volunteer workers (many for seal sale).

Type of work: Home visiting, clinic, classes, hospital and health center. Summer camps have been conducted but have been replaced by a permanent Preventorium at Livermore, California, called Del Valle Preventorium, which houses forty-eight children—24 boys, 24 girls.

Financial: The total budget for the year (allowed by Community Chest) is

\$21,219.17. It is hoped to get \$50,000 from the 1924 Christmas seal sale. The organization is supported by seal sale, membership dues (included in above budget), special contributions and Community Chest.

General Statement: Public Health Center of Alameda County has taken over work started and sponsored by the Tuberculosis Association. Both are working closely together, the Association paying salary of nurse, and furnishing cars for transportation of different workers.

THE PUBLIC HEALTH CENTER OF ALAMEDA COUNTY

Organized 1918.

Aim: To increase the efficiency of public health, relief and welfare work of its community.

Board: The governing board consists of 7 members.

Territory: The organization serves a territory with an urban population of 360,000, and a rural population of 240,000.

Staff: Physicians: 2 full-time, 10 part-time. Dentists, 3. Nurses, 18. X-ray technician. Laboratory technicians, 2. Pharmacist. Executive staff, 12.

Type of work: Home visiting, all ages. Medical, social service, bedside and public health nursing, clinics and classes, health center, dental mobile unit, post-graduate field of research in special problems for University of California.

Financial: The center is supported by funds derived from the following sources: county, Junior Red Cross, private, Community Chest, Red Cross shop, Red Cross, Parent-Teacher Association and clinic funds.

San Francisco

BABY HYGIENE COMMITTEE, SAN FRANCISCO BAY BRANCH OF THE AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

Organized 1909.

Aim: The maintenance of a children's health center for the instruction of mothers in the feeding and hygiene of infants and children of pre-school age; maintenance of a health center and feeding conference for foster babies of Associated Charities; training of doctors and lay workers in the conduct of health centers.

Board: The governing board consists of 25 women.

Territory: The Committee serves an urban territory with a population of 600,000.

Staff: 7 doctors, 1 dentist, 21 clerical workers, 1 visiting nurse and postnatal nurse, 1 physical educator.

Type of work: A health center is maintained for infants, pre-school and dependent children. Home visiting and educational work is carried on.

Financial: The Committee is supported by the community chest.

General statement: Since the organization of the first child health center in 1909 until the present time, the Baby Hygiene Committee has steadily widened its scope. It established the idea of taking care of the well child, of weekly health conferences and food instruction. As an educational piece of work, it taught the mother to care for her child intelligently under scientific instruction. Three days each week are given over to the infant, one day to the dependent child of the Associated Charities in foster homes and one day to the runabout child. A dental

hygienist is in weekly attendance and teaches the care of the mouth, the importance of the first teeth and the use of the tooth brush. There is a weekly posture class where a physical educator corrects postural defects through exercise. A visiting nurse attends all conferences and assists the mother to carry out doctor's instructions in the home. Children between the ages of 18 months and two years are advanced to the runabout class. Graduation parties are held twice yearly at which each child is presented with a health diploma containing its health history. Talks on the health of the runabout child are given to the mothers by the doctors in charge.

A prenatal nurse has been added to the staff. Her services are given to three hospitals—University of California, Stanford and the Children's. Her duty is to visit all maternity cases within 24 hours of the mother's return home from the hospital and give a teaching demonstration in the bathing and care of the infant.

Last year there was an attendance of 3,876 children.

For six months a weekly lecture was given on prenatal care. This also included a complete demonstration for the care, clothes and nursery equipment. Two newspapers published 16 lectures written by our physicians on mother and infant welfare. Special questions were answered through the columns and by letter. The Baby Hygiene Committee cooperates with the San Francisco Board of Health in its welfare work and with the Associated Charities in presenting educational lectures. The Committee also looks up all birth registrations.

BUREAU OF CHILD HYGIENE, CALIFORNIA STATE BOARD OF HEALTH

Organized January, 1920.

Aim: Establishment of prenatal and infant welfare centers in rural communities, reduction of infant and maternal mortality rates, introduction of nursing service in rural communities, etc.

Board: Seven members of State Board of Health.

Territory: The Bureau serves the entire state.

Staff: Director, supervising nurse, financial clerk, statistical clerk, stenographer. Appointment of assistant director pending. County nurses, 3 full-time, 11 part-time.

Type of work: Home visiting, classes, health centers, mobile units, own publication.

Financial: The Bureau is supported by state appropriation and federal funds of the Sheppard-Towner Act. Budget for the year approximately \$25,000.

General statement: The Bureau is doing educational work under the Sheppard-Towner Maternity and Infancy Act.

CALIFORNIA DAIRY COUNCIL

Organized January, 1919.

Aim: To arouse the people to a realization of the necessity for a liberal use of milk products in the diet of children, to enlighten the public concerning the value of dairy products in maintaining the bodily and mental vigor of adults; to aid in increasing production, and raising standards of quality; to improve methods of manufacture and distribution, and to stabilize prices.

Board: The Council is governed by a board of 45 directors.

Territory: The organization is state-wide in its scope and as such serves about four million people.

Staff: A secretary-manager, publicity director, 3 nutrition workers, 2 field men, 6 clerical assistants.

Financial: The Council is supported by membership dues.

Type of work: The activities of the California Dairy Council fall naturally into the following divisions: educational work on the nutritional value of dairy products as human food; dairy improvement work; educational work on the importance of the dairy industry to the economic welfare of the state; and legislative work in the protection and encouragement of the dairy industry.

General statement: Meetings were held throughout the state with groups of school teachers, parents, school officials, school nurses, club women, business men, dairymen, bankers. Members of the staff addressed these meetings.

Much has been accomplished in furthering milk service in schools. Upwards of 75,000 half-pints of milk a day are now distributed in the California schools. Almost every city has a regularly organized milk service in the schools.

Council work has been carried on in cooperation with Parent-Teacher Associations, school authorities, etc., in Alameda, San Francisco, Sacramento, Marin, Sonoma, Mendocino, Contra Costa, Fresno, Tulare, Santa Clara, Los Angeles, Riverside, Orange, Imperial, and San Bernardino Counties.

Some work has been done in practically every county in the state, "Dairy Products for Health" campaigns were carried on during the year 1923 in Alameda and Imperial Counties. The Council has also participated in a number of special campaigns initiated by other agencies.

During the year large quantities of literature, posters, charts, and a number of books, such as Dr. E. V. McCollum's "American Home Diet," were distributed. Lectures were given in Berkeley, San Francisco, Sacramento and Petaluma by Dr. McCollum under the auspices of the Council.

Santa Barbara

VISITING NURSE ASSOCIATION

Organized 1908.

Aim: To furnish visiting nurse service to the community and to promote the interests of public health.

Board: The governing board consists of 15 women.

Territory: This Association serves a city and urban territory with a population of 28,000.

Staff: Superintendent; doctors, 2 volunteer; nurses, 1 supervising, 4 staff; dental director, 1 part-time dentist; clerical assistant, 1.

Type of work: Home nursing care for all ages; infant welfare, dental, tuberculosis and heart clinics; open air school and school nursing.

Financial: The total budget for the year is \$17,729.77. The organization is supported by the Community Chest.

General statement: The Association cooperates with the Associated Charities, Cottage Hospital dispensary, School Department and Psychological Research Bureau. During the year 12,662 visits were made by the staff.

COLORADO

Colorado Springs

COLORADO SPRINGS DAY NURSERY

Organized 1897.

Aim: To provide a home for children whose parents are unable to care for them, to prevent permanent separation of families, to promote child welfare in the community, wholly non-sectarian.

Board: The governing board consists of 20 members.

Territory: El Paso County.

Financial: Budget, \$18,500. The nursery is supported by the Community Chest, Children's Board and endowment fund.

General statement: The nursery has recently occupied a large building, a \$300,000 gift from its president. The work is to be greatly enlarged and developed along the line of all of the most modern methods of child welfare and improvement both in health, which is to be a prominent feature, and the daily care and education of the child. Greater helpfulness to parents and more intensive investigation is planned. The organization is not only a day nursery, but cares for from 30 to 50 children at night. Some have been 2 and 3 years with the nursery, which assumes all care, but leaves responsibility to the parent if possible. The nursery has a completely equipped hospital and pays especial attention to children of tubercular parents. No communicable disease cases are handled. The medical staff is the best in the city, and the children have all the tender care and attention of home, far better than they would receive in their own homes.

Denver

COLORADO CHILD WELFARE BUREAU

Organized 1919.

Aim: To secure a wiser and better trained parenthood and to cultivate such a healthy and happy childhood as shall insure the development of an ideal citizenship for the state.

Board: The governing board consists of two men and three women.

Territory: The work of the Bureau covers an urban territory with a population of 256,369 and a rural territory with a population of 550,000.

Staff: Executive secretary, consulting surgeon, organizer, 2 pediatricians, supervisor of nurses, 1 full-time and 2 part-time maternity and infancy nurses, 1 office secretary and 1 clerk.

Type of Work: The Bureau acts through all organizations for better parenthood; places children where they may receive proper care physically and mentally; promotion of the welfare and hygiene of maternity and infancy, cooperation with the Federal Children's Bureau, Department of Labor, Washington, D. C.

Financial: The total budget for the year is \$4,000 for child welfare and the budget for the state under the Sheppard-Towner Act is \$15,000 annually, making a total budget for the Bureau of \$19,000 annually.

COLORADO TUBERCULOSIS ASSOCIATION

Organized October, 1918.

Aim: To work, chiefly by educational and preventive methods, towards the eradication of tuberculosis.

Board: Directors, 72; Executive Committee, 10.

Territory: The Association serves a population of approximately one million, urban about 450,000, rural over 500,000.

Staff: Executive, field and publicity secretaries, office manager, stenographer, usually a field nurse. The urban work is carried on by 9 local associations.

Type of Work: Home visiting, clinics, classes, mobile unit for pre-school and school ages.

Financial: The source of funds is the Tuberculosis Christmas Seal sale in Colorado.

General Statement: The larger part of the work of the Association lies in developing health education in the rural schools, over half of the children of the state being in the rural districts. Phases of the work include examination of the children by the field nurse, teaching teachers, in small groups and at institutes, developing public health nursing, exhibits, Crusade, nutrition program, a traveling clinic in cooperation with three other state organizations, etc. A state tuberculosis hospital is also on the program. Community Chests, however, have resulted in such a cut in the budget that the Association is in a critical situation financially.

THE DENVER TUBERCULOSIS SOCIETY

Organized October, 1917.

Aim: To control and prevent the spread of tuberculosis.

Board: The governing board consists of 22 men and 14 women.

Territory: The work of the society covers an urban territory with a population of 256,369.

Staff: An executive secretary, 4 nutrition workers, 8 physicians, part-time, 1 case worker for the tuberculous at the City Charities, 1 housing worker, 1 clerical worker, 1 matron at open air school.

Type of Work: A general health education program and nutrition classes in public and parochial schools, in orphanages and dispensaries. In the general program the work is confined chiefly to the first three grades and much attention is given to correlating the health teaching with the other subjects. Medical inspection in the parochial schools is provided, as well as a physician for the open air school. An average gain of 275 per cent, or nearly three times the normal rate of gain, was obtained for 300 children enrolled in the classes during the year. The 56 children who attended open air school during the year made an average gain of 11 pounds each in a 20 weeks' period.

Orphanages and other institutions in the Chest are given advice along dietary lines by the Society's staff.

The housing worker visits and investigates the boarding houses for the tuberculous in Denver, and places patients in sanatoria and boarding houses.

Financial: The budget for the year was approximately \$27,500. The Society is supported by the Community Chest and the sale of Christmas Seals.

VISITING NURSE ASSOCIATION

Organized: 1904.

Aim: Generalized public health program.

Board: The governing board consists of 30 women.

Territory: The Association serves the city and county with a population of 290,000.

Staff: The staff consists of a superintendent, medical director and infant welfare doctors who serve part-time, 3 supervising and 23 staff nurses and 4 clerical assistants.

Type of work: Home nursing care for all ages, and all types of disease, infant welfare stations, and day nursery inspection.

Financial: The Association is supported by the Community Chest, private donations, subscriptions, and memberships.

General Statement: The Association cooperates with the City Charities, Social Service Bureau, Denver Tuberculosis Association, Colorado Tuberculosis Association, and all other agencies of the city. The nurses made 56,260 visits and cared for 8,009 patients during the past year.

CONNECTICUT

Bridgeport

CITY DEPARTMENT OF HEALTH, BUREAU OF CHILD HYGIENE

Aim: To promote and safeguard the health of the children of the city.

Territory: The entire city with a population of 155,000 is covered by the Bureau.

Staff: Doctors, 2; supervisors, 2; clerical assistants, 1; field nurses, 23.

Type of Work: Home visiting for prenatal, postnatal, infancy, and pre-school groups. Daily visits to all schools and follow-up visits to homes of school children. Five health centers are maintained for infants and pre-school children. The work is preventive and educational.

The Division of Dental Hygiene operates as an integral part of the Bureau of Child Hygiene. The work is carried on in all schools of the city and comprises prophylactic treatments and educational talks. Children with dental defects are referred to their own dentists or, if family is without funds for necessary work, to a dental clinic maintained by the Division or to that maintained in the Municipal clinic. In this division there are: 1 dentist; 1 supervisor; 16 dental hygienists.

Financial: Total appropriation for Bureau, \$66,000.

DEPARTMENT OF PUBLIC CHARITIES

Organized: 1836.

Aim: Organized for the purpose of caring for the poor of the city.

Board: The governing board consists of 3 men and 1 woman.

Territory: The work of the Department covers an urban territory with a population of 148,152.

Staff: A supervisor of the Department; nurses, 3 district, 10 institutional; social workers, 8; clerical assistants, 15.

Type of Work: The work includes: Care of sick; care of dependent chil-

dren; care of dependent families; supervision of tuberculosis and prenatal cases attending clinic.

Financial: The total budget for the year was \$263,000. The Department is supported by public funds.

THE VISITING NURSE ASSOCIATION OF BRIDGEPORT, INC.

Organized: 1910.

Aim: To provide trained nurses for the benefit and assistance of those otherwise unable to secure skilled care in time of sickness; to give instruction as to the care of the sick and the laws of healthful living, sanitation and hygiene. The Association is not responsible to any ecclesiastical institution. It is supported by and serves persons of all creeds, nationalities and colors.

Board: There are 36 members of the governing board.

Territory: The Association serves an urban population of 143,000.

Staff: Superintendent, assistant superintendent, supervisor, 19 graduate nurses.

Financial: Funds are secured from the Financial Federation, Christmas Seals, paying patients, Metropolitan, Industrials. The budget for the year is \$50,801.86.

General Statement: The Association gives general nursing service in the homes of the people of Bridgeport. It has a prenatal, obstetrical delivery, postpartum service and tuberculosis nursing. Through its health camp, Hemlocks, there is a very definite opportunity for health building for children both from preventive and convalescent standpoints.

Hartford

CITY OF HARTFORD CHILDREN'S HEALTH STATIONS

Organized: 1905.

Aim: To reduce infant mortality and to improve the health of children.

Board: Joint Committee composed of 3 members of the Board of Health Commissioners of the City of Hartford.

Territory: The stations serve an urban territory with a population of approximately 152,000.

Staff: The medical staff is under the direction of the Health Officer and two Board of Health physicians and the nursing service under the direction of the Visiting Nurse Association. The staff consists of 5 physicians, 1 supervising nurse, 10 staff nurses, 1 nutrition worker, 2 clerical assistants and a group of volunteer aids.

Type of Work: Health conferences for infants and children of pre-school age, educational health work in the homes of infants and children registered at the stations, and with expectant mothers, and to some extent with the mothers of all babies whose births are registered, in an effort to get every child under regular health supervision.

Financial: The work is entirely supported by the city, the equipment of the stations having been turned over to the city without charge.

General Statement: It is interesting to note that for the nine months' period, the death rate among this group of about 3,000 has been approximately one-half that of the same age group for the entire city, and that the work has cost the city only \$4 per child. As an operating experiment in cooperative health education, the year's work of the stations has been exceedingly successful.

CONNECTICUT STATE DEPARTMENT OF HEALTH, BUREAU OF CHILD HYGIENE

Territory: State of Connecticut.

Staff: Director (M.D.), secretary, field organizer (R.N.), supervisor of field workers (R.N.), 3 field workers (P.H.N.'s), 1 instructor of midwives (R.N. and licensed midwife), 2 clerks.

Financial: Bureau financed by the state.

Type of Work: 1. Surveys: Through vital statistics to learn the infant mortality rate and to ascertain the causes of death; through house to house canvass to investigate living conditions relative to infant and maternal mortality, and if any illness in the family exists, to find its nature.

2. Cooperation: Through acquaintance to gain the help of the medical profession, and all state and local women's organizations, for the furtherance and success of the work.

3. Educational: To increase the number of women's hygiene clubs and prenatal classes; to instruct young women in physical preparation for womanhood and future motherhood; to demonstrate correct care of children; to form nutrition classes with lectures on diet of infants and children, also of expectant mothers; to distribute feeding pamphlets to all mothers of young children, literature to expectant mothers, and to organize classes for the instruction of midwives; to issue literature prepared by the Department for the advice and instruction of mothers regarding the care of themselves and their children.

4. Well-baby conferences: To increase the present number of well-baby conferences, to teach mothers how to keep their babies well; to detect physical defects, if existing, and to have them corrected through reference to the family physician; to teach mothers that their children may begin school at six years of age in good physical condition.

The well-baby conferences are opened after the Bureau has been assured of the friendship and cooperation of the local health officer and physicians, also of the support of the citizens of the town, with the physicians supplying the professional work of the conferences and the citizens doing the lay work. The work of these conferences is thus done by the towns in which they are held. After the opening of the first conference, the Bureau acts only in an advisory capacity. To make the work permanent and of lasting value in the community, the hygiene nurse is detailed to do the follow-up work in the homes. Any child having been found to have a defect, is kept under observation by the field worker who sees that the mother gets the child to her own family physician for care, or through his advice to the hospital whenever operative work is required.

The prenatal work is purely educational. Cooperation is first secured from the health officer and the physicians of the community, then the interest of the clergy and presidents of every woman's organization and girl's organization is secured. An initial meeting of the women of the local committee is called and a representative committee is chosen. A course consisting of a series of 9 lectures, demonstrations, and moving pictures is given. Special stress is placed upon the importance of the nutrition of the expectant mother and the young child. This work is carried on principally in the rural districts where there is no visiting nurse association and the nearest physician is located at a great distance.

5. Nursing service: To do follow-up work—in connection with the well-baby conferences to help mothers see the importance of having the defects of their children corrected—to give instruction in prenatal, maternal and child hygiene.

6. Hygiene inspection: Through cooperation with existing agencies to seek to standardize conditions in day nurseries, children's homes, foundling institutions, kindergartens, and all places where young children are associated together in numbers.

7. Publicity: Through cooperation with the Bureau of Public Health Education, to work in any way it may indicate to promote the service, by giving exhibits, demonstrations; by using lantern slides, moving pictures; by giving lectures, and securing the courtesy of the press.

Middletown

THE DISTRICT NURSE ASSOCIATION

Organized: 1900.

Aim: The object of this Association is to give to the sick and especially to those of limited means, the best home nursing under existing circumstances.

Board: The governing board includes the 5 officers and 35 other members.

Territory: The Association serves an urban and rural territory, including Middletown and Portland.

Staff: Nurses: 8 registered, 1 student from Middlesex Hospital.

Type of Work: Home visiting, clinic conferences.

Financial: Funds are derived from legacies invested, Metropolitan Life Insurance Company, private patients, membership dues, special gifts, Christmas Seals, and from the Russell Manufacturing Company for an industrial nurse. The budget for the year is \$16,251.

General Statement: In June, 1915, the Association assumed charge of the baby welfare work which was started in 1909 by the Social Service League of Middletown. At the present time the work is being reorganized and the pre-school child is being included in the Child Hygiene Department. The Director of the Bureau of Child Hygiene of the State Department of Health is assisting in making the change. There are 526 babies under the care of the Association and three weekly conferences are held in Middletown, and one in Portland.

New Haven

ALUMNAE ASSOCIATION OF THE CONNECTICUT TRAINING SCHOOL FOR NURSES, INC.

Organized January, 1891.

Aim: To make of the association an active participant in the welfare of the community.

Board: President, vice-president, second vice-president, secretary, treasurer, and six directors.

Financial: The Association is supported by membership dues and fees.

General Statement: The Association was reorganized during 1923 and a constitution conforming to the National was adopted.

CRIPPLED CHILDREN'S AID SOCIETY, INC.

Organized January 14, 1914. Incorporated December 21, 1914.

Aim: Relief of crippled children by affording them material assistance in pro-

viding medical and surgical care, in supplying orthopedic appliances and in providing such means of hygienic and social betterment as may tend to remove the handicap to the children's welfare and happiness which their unfortunate situation has imposed.

Board: The Society is governed by a board of 13 men, as trustees, and an executive board of 15 women.

Territory: The work of the Society is carried on in New Haven and outlying districts.

Staff: There are no paid executives, the services of the managing board being voluntary. The medical board consists of three doctors, one of whom is in charge and doing active work. The physician who is supervisor of medical service, whose services are voluntary, gives about seven hours weekly to the care of these children. A registered nurse is in charge with one paid assistant, and a paid office assistant on part time.

Type of Work: The work includes orthopedic clinics (weekly), social service, hospital and home nursing, advisory care and corrective exercise classes.

Financial: The total budget for the year was \$15,000. The Society is supported by the Community Chest and membership dues. The care of the children is free, except where the parents can contribute a small payment to the Society.

General Statement: Beginning October 1st, 1923, by special arrangement with the New Haven Orphan Asylum, we placed ten of our children with them for much needed convalescent care. The results thus gained, following operations, have proved the wisdom of our venture. The Board of Education has provided a teacher for these children for three hours each school day. At present we are working in cooperation with the Board of Education over the problem of the crippled children who are unable to attend school. We confidently expect that the solution will be the establishment, in New Haven, of a special classroom for these children.

NEW HAVEN VISITING NURSE ASSOCIATION

Organized: 1905.

Aim: To care for the sick in their homes, to teach the family to care for the patient, to teach health habits and home hygiene.

Board: The governing board consists of 36 women, with an advisory board of 7 men.

Territory: The Association serves a city population of 172,000, and a suburban community of 15,000.

Staff: The staff consists of a superintendent, an associate superintendent, 6 supervisors, and 43 field nurses. Home Economics Department: 1 supervisor, 1 assistant supervisor, and 6 field workers, registrar, and 5 clerical assistants. The Association has a number of volunteer workers through the Junior League, each giving about two hours weekly to the child welfare work. The number of volunteers varies considerably during the season, fewer in summer than in winter. They probably average about ten or twelve weekly.

Type of Work: Home nursing, with preventive and educational work.

Financial: The Association is supported by collections from patients and from the Metropolitan Life Insurance Company for its policy holders, special contributions, an appropriation from the city, and the Community Chest. A fee of 85 cents per visit is collected if the patient can pay. The total budget for the year was \$113,607.84.

General Statement: The report is for the whole organization as the Child Welfare Department has been absorbed into the generalized program. Although each nurse is directly responsible for the care of the children in her own district, the child welfare work is still under the direct supervision of a specialized child welfare nurse. During the year 3,914 children were taken under care, 987 of these being less than one month old. The greater number of these children will be kept under care until they reach school age. The Association conducts one prenatal conference, 16 well-baby conferences, and 10 conferences for the pre-school child, in this way helping to protect the child life of the city. There is a doctor in attendance at the conferences, the Association paying the doctor three dollars for each conference attended.

YALE PSYCHO-CLINIC

Organized: 1911.

Aim: To develop the diagnostic, advisory, and research phases of the work of the clinic.

Board: The clinic is a part of Yale University Polyclinic.

Territory: The services of the clinic are not restricted to New Haven but are available to any persons or agencies in the state.

Staff: Director and 2 clinical assistants.

Type of work: Classified by types of service the cases are subdivided as follows: 1. Diagnostic and consultation service. 2. Follow-up and cooperation service. 3. Clinical treatment. 4. Research.

Financial: The clinic is supported by the University.

General Statement: The clinic still conducts part of its work at the New Haven Dispensary, but its laboratory, files and headquarters are now located at 28 Hillhouse Avenue. In addition to the regular clinical service, the clinic is used for teaching, demonstration and research purposes. Twenty-five local and state agencies refer cases for mental diagnosis and advice as to treatment and social disposition. Practically all of the clinical work is done on an appointment basis. No fees are charged. Detailed records of each case are kept on file and written reports made for agencies.

The total number of mental examinations made for the period from September, 1923, to June 1, 1924, was 622. The total number of cases handled in this period was 581.

Diagnostic and consultation service is the most frequent. Ordinarily the disposition of a case referred depends upon the diagnosis and the consequent recommendations. In the second and third types of service the clinic attempts, so far as its resources permit, to follow up the case into the home or institution, usually with the cooperation of persons or agencies most interested. In special instances detailed programs of child guidance are undertaken.

The systematic research of the clinic deals with the mental development and mental hygiene of children of pre-school age. An investigation of norms of development was undertaken in 1919 and the results have been published in a volume which reports the data and details of clinical procedure for developmental diagnosis and developmental supervision. During the past year a mental survey was made of exceptional children in New Haven kindergartens. Developmental examinations have also been made of children admitted to the New Haven Nursery School and to the Junior Kindergarten of the Neighborhood House.

New London**JOSEPH LAWRENCE TRAINING SCHOOL, LAWRENCE AND MEMORIAL ASSOCIATED
HOSPITALS**

Organized: 1913.

Aim: Nursing education in general hospital methods.

General Statement: Students have a three months' affiliated course in pediatrics in the Yale School of Nursing. Four students have been sent annually in the past for three months to New York Nursery and Child's Hospital. The School has had its own course in pediatrics, including demonstrations. There has been no course in visiting nursing, but the school has been present at some of the city baby clinics, which are especially active in New London. The state sent out the heads of the different bureaus of the Health Department to lecture and give screen talks, 16 in all. The School attended most of the talks having a direct bearing on child health.

The new Maternity Building has been opened about a year and a half, last year showing 275 deliveries. Each student has charge of at least twelve deliveries. The third floor of the Maternity Building and the adjoining roof is well fitted for children and this year there has been an active service. There is also a 25 bed Contagious Department.

Norwich**CONNECTICUT ORGANIZATION FOR PUBLIC HEALTH NURSING**

Organized in 1906.

Aim: To stimulate interest in the establishment and extension of public health nursing in the state, and to bring women engaged in the work into closer relationship with one another.

Board: The Organization is governed by a board of 9 women.

General Statement: The membership consists of public health nurses, who are registered nurses, engaged in public health nursing, and the boards of directors of Visiting Nurse Associations. Three times a year round tables are held, with speakers on public health nursing and allied subjects. The Organization has worked in closest cooperation with the Bureau of Public Health Nursing, Connecticut State Department of Health.

Waterbury**WATERBURY VISITING NURSE ASSOCIATION**

Organized: 1903.

Aim: To care for the sick and to teach hygiene and child care by actual demonstration in the home.

Board: The governing board is formed of a Board of Directors comprising 11 men and an Executive Committee, comprising 2 men and 6 women.

Territory: The Association serves an urban territory with a population of approximately 91,516.

Staff: Superintendent, 11 part-time doctors, a supervisor of child welfare and prenatal work, and 12 staff nurses.

Type of Work: Prenatal work is done through home visiting and weekly clinic.

Postnatal, bedside care and instruction are given to patients who have been attended by a physician. Infants are kept under supervision through home visiting until they are two years old. Infant welfare conferences are held in six sections of the city each week. Six Little Mothers' League classes covering a course of 12 lessons are conducted. Cases of communicable disease and of tuberculosis are given bedside care when necessary.

Financial: The budget for 1924 was \$31,000. The Association is supported by an endowment fund, by fees, and by special contributions.

General Statement: Pre-school conferences have been discontinued because of lack of nurses to do the necessary amount of follow-up home work. The nurses have been more successful this year in having the babies brought to the baby welfare stations for supervision. The Junior League supplies volunteer service for clerical work and weighing at the three largest stations. The Association had a booth at the Industrial Exposition held at the local Armory the first week of June and counted 11,256 visits.

DELAWARE

Dover

CHILD HYGIENE DIVISION, STATE HEALTH AND WELFARE COMMISSION

Organized 1918, as a part of State Council of Defense. Organized in 1921 as the Child Welfare Commission. Reorganized in 1923 as the State Health and Welfare Commission.

Aim: To take over and further develop the child welfare activities conducted by the Child Welfare Commission of the State of Delaware; to cooperate with state, county, and local official bodies in the development of such child welfare work as the Commission may believe will materially advance the interests of the children of the state; to make a study of the needs of children a definite part of its work, and to make recommendations for executive and legislative action in matters relating to children.

Board: The governing board consists of four physicians and three women.

Territory: The work of the Commission covers both urban and rural territory, with a total population of 244,000.

Staff: Doctors: 1 executive secretary, 9 doctors part time. Nurses: 1 supervisor, 9 staff nurses. Clerical assistants: 6. Members of the Catholic Daughters of America and the Junior League are volunteer workers.

Type of Work: The Commission has to do with all matters pertaining to child welfare with the possible exception of the Juvenile Court. Home visiting, clinics, classes, and health centers are maintained.

Financial: The budget for the year is \$25,000. The Commission is supported by an appropriation from the state. It also administers the Federal Sheppard-Towner Funds.

General Statement: In the city regular visits to the center are required. They vary from two weeks to one month for each case, though special cases are required to come more frequently. In rural work this scheme is not possible. The frequency with which the nurse visits these families is dependent on the weather and the roads. All nurses, whether rural or urban, must put in at least one-third of their time on prenatal, infancy and pre-school child work, with the emphasis on the prenatal and

infancy groups. The visits of the nurses are instructive and educational. Home care is given only in emergency. Cases needing special care are referred to the hospitals.

DISTRICT OF COLUMBIA

Washington

HEALTH DEPARTMENT CHILD HYGIENE SERVICE

Organized July 1, 1923.

Aim: Conservation of child life through the education of parents.

Control: Health Officer, District of Columbia.

Territory: The Society serves an urban territory with a population of 437,571.

Staff: Doctors: 1 medical director, part-time, 6 part-time; 1 executive secretary. Nurses: 1 supervisor, 5 staff.

Type of Work: The Service establishes and conducts stations where mothers are taught how to care for the well baby and child; it instructs mothers in modification of milk, feeding, bathing, and home sanitation; when necessary it secures homes for babies and children, wet nurses, and part-time work for mothers.

Financial: The Service is supported by a Congressional appropriation of \$18,000.

General Statement: The statistical report shows that 2,201 individuals have received health supervision during the year; and that 12,934 home visits have been made by the nursing staff. This report is for the fiscal year ending June 30, 1924. The Health Department of the District of Columbia took over five stations maintained by the Child Welfare Society on July 1, 1923, and has maintained them.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

Organized February 17, 1897.

Aim: Child welfare in home, school, church and community.

Board: The governing board consists of 94 members.

Territory: The work of the organization is national in scope, covering both urban and rural communities.

Staff: Executive secretary, 2 office assistants, field secretary, 3 organizers.

Financial: Funds are derived from membership dues, and contributions for extension made by members. The budget is approximately \$40,000.

Type of Work: Organization of Parent-Teacher Associations, establishment of kindergartens and the distribution of literature which is of practical use to parents.

General Statement: This organization operates through state branches in 46 states and the District of Columbia, and through local associations in the 2 states not yet ready for organization. It divides its work into 5 departments, Health, Public Welfare, Home Service, Education, Organization and Efficiency. Its 31 committees are grouped under these departments, and include such as Child Hygiene and Child Development, Physical Education, Pre-School Circles, Social Hygiene, Country Life, Home Education, Recreation, Home Economics, etc.

FLORIDA

Jacksonville

BUREAU OF CHILD WELFARE AND PUBLIC HEALTH NURSING, STATE BOARD OF HEALTH
Organized in 1915.

Aim: Conservation of maternal and child life.

Board: The governing board consists of 3 men.

Territory: The work of the Bureau is state-wide and serves a population of approximately 800,000.

Staff: Director, 12 staff nurses, 1 full-time and 1 half-time clerical assistant, and auditor.

Type of Work: Supervision, instruction and examination of midwives. Home visiting for maternal, prenatal, obstetrical, and postnatal cases, infancy, pre-school and school age groups; clinics for infants and pre-school children; class on maternal, prenatal, obstetrical, infant and pre-school care.

Financial: The Bureau is supported by Federal and state appropriations with a budget of \$27,031.72.

General Statement: The Bureau has cooperated with the Children's Bureau of the United States Department of Labor in the promotion of the welfare and hygiene of maternity and infancy as outlined in the Sheppard-Towner Act.

GEORGIA

Atlanta

STATE ASSOCIATION OF GRADUATE NURSES

Organized: 1904.

Aim: Advancement of the profession of nursing in Georgia.

Board: The governing board consists of 13 members.

Territory: The state of Georgia.

Financial: The organization is supported by membership dues and income from invested funds.

Augusta

CHILDREN'S HOSPITAL ASSOCIATION

Organized in 1900.

Aim: To provide free hospital care for white children of Richmond County and private care for women and children.

Board: The governing board consists of 12 men and 17 women.

Territory: The Association covers an urban territory with a population of 53,000 and a rural territory with a population of 12,000.

Staff: Superintendent, 1 resident physician, 3 graduate nurses, and Training School for Nurses.

Type of Work: A general hospital for children and women. The hospital cooperates with the Augusta Clinic, City Dispensary, and Public Health Nursing Service.

Financial: The hospital is supported by appropriations from city and county, dues, contributions, small income from endowment, and fees from private patients. Expenses about \$20,000.

ILLINOIS

Chicago

AMERICAN DENTAL ASSOCIATION

Organized: 1859.

Aim: To cultivate and promote the art and science of dentistry, and of its collateral branches; to conduct, direct, encourage, support or provide for exhaustive dental and oral research; to elevate and sustain the professional character and education of dentists; to promote among them mutual improvement and intercourse, and good will; to disseminate knowledge of dentistry and dental discoveries; to enlighten and direct public opinion in relation to oral hygiene, dental prophylaxis, and advanced scientific dental service, and in relation to the advantages and progress of enacting and enforcing proper, just, and uniform dental laws in the several states; and collectively, to represent, have cognizance of and to safeguard the common interests of the members of the dental profession; with express power to acquire property for the purposes of the corporation by purchase, deed, gift, bequest or otherwise, and to hold and administer the same and to publish dental journals, reports and treatises. The department of dental health education purposes to supply non-technical material for the education of the laity and to emphasize the educational aspect of the dental problem.

Territory: The Association has 35,000 members located all over the United States.

CHICAGO LYING-IN HOSPITAL AND DISPENSARY

Organized February, 1895.

Aim: To provide medical and nursing care to women at time of confinement; also, to instruct doctors, students, and nurses in the art of obstetrics.

Board: The governing board of the hospital consists of 4 men and 35 women.

Territory: The hospital serves an urban territory with a population of 2,701,705.

Staff: Superintendent of the hospital and a superintendent for each of the branches of the hospital; doctors, 1 director of obstetrical service, 15 full-time, 26 part-time; nurses, 1 superintendent of nurses, 1 director of obstetrical service, 13 supervisors, 7 staff, 53 pupils; social service, 1 director, 4 full-time, 3 part-time; volunteer service, 3.

Type of Work: Home visiting, delivery of women in their own homes, clinics, and research work are carried on in addition to the regular hospital work.

Financial: The budget for the year was \$296,464.60. The hospital is supported by membership dues and special contribution. Fees are regulated for each patient.

General Statement: During the year 12,131 patients visited the clinic; 25,320 home visits were paid by the staff; 1,524 patients were given home care; 6,808 patients received hospital care. The infant mortality rate was 2 per cent. The age limit for baby conferences is 18 months.

MOTHERS' AID OF THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY

Organized: 1904.

Aim: To promote the best interests of the Chicago Lying-In Hospital and its dispensaries.

Board: The governing board consists of 40 women.

Type of Work: The organization maintains a ward and a private room in the Chicago Lying-In Hospital known as the "Ida De Lee Newman Ward" and the "My Mother Room." It provides the institution with mothers' and babies' wearing apparel; lends assistance to poor women in the state of pregnancy, and furthers the charitable and educational purposes of the institution.

Financial: The organization has an income from membership dues, initiations, life memberships and the various funds.

The Mothers' Aid built and equipped the "Mothers' Aid Pavilion," a valuable adjunct to the Hospital, where all septic cases are cared for; it provides funds for research work in the Pavilion and makes practically all the supplies used by the Hospital, its dispensaries and the Pavilion. The Junior Auxiliary sends a great portion of their income to the dispensaries for distribution of milk. These same young women assist at all the baby clinics, besides making wearing apparel for the babies.

CHICAGO WOMAN'S CLUB

Organized February, 1876.

Aim: Organized for educational, civic and philanthropic purposes.

Board: The governing board consists of 24 women.

ELIZABETH MCCORMICK MEMORIAL FUND

Organized May 20, 1908.

Aim: To improve the condition of child life in the United States.

Board: The Board of Trustees consists of 6 men and 2 women.

Territory: The organization serves the entire United States.

Staff: Acting Director. Physicians: staff 1, part-time examining 2, consultants 2. Nutrition Department: full-time nutrition workers 4, part-time 1, clerk 1. Health Education Department: supervisor 1, assistants 3. Psychologist 1. Technical Consultant 1. Speakers 2. Librarian 1. General 9.

Type of Work: The activities of the organization have been concentrated on promoting the health of children. It maintains the National Directory of Open Air Schools, and furnishes information on methods, equipment and construction, with a view to standardizing open air schools throughout the country. The Fund is making experiments and demonstrations in health education and studies on the growth of children. Nutrition classes for undernourished children are maintained and promoted.

Financial: The organization is supported by an endowment. Total budget for the year, \$90,386.

General Statement: Members of the staff of the Fund have directed courses of study at normal schools and colleges and state universities, and have assisted local communities in planning and starting health service for children. The Fund cooperates actively with such organizations as the United Charities, Pension De-

partment of the Juvenile Court, and various children's institutions, in planning their health service. Lecturers may be secured through the Speakers' Bureau. The Fund also maintains a Child Welfare Library, is a distribution center for literature on child welfare and kindred subjects, and has a wide choice of exhibit material which it loans free of charge, excepting for the cost of transportation.

INFANT WELFARE SOCIETY OF CHICAGO

Organized: 1910.

Aim: The object of the organization is to keep babies well by advice, by supervision, by encouraging breast feeding, and by instruction of the mothers in the rules of hygiene.

Board: The governing board consists of 30 men and women.

Territory: The Society serves part of the city of Chicago.

Staff: Superintendent, 1 medical director, 1 associate medical director, and 27 doctors, part-time, 4 supervising and 39 staff nurses, 1 supervising dietitian and 6 staff dietitians. The office staff consists of 1 extension secretary, and 4 clerical assistants.

Type of Work: Conferences, nutrition clinics, and prenatal clinics are conducted. The mother is instructed as to the nursing of her child; when breast feeding is impossible, an adequate milk modification is prescribed.

Financial: The budget for the year was \$150,000. The Society is supported by private contributions.

General Statement: Infant welfare conferences are held twice a week in the 27 centers. Nutrition classes are conducted weekly in 13 stations, and in 7 stations prenatal clinics are held weekly. One new prenatal clinic has been opened during the year.

Freeport

CHILD WELFARE SOCIETY

Organized February, 1918.

Aim: Child welfare, dealing with the period from prenatal life to school age.

Board: A governing committee of fourteen women.

Territory: The Society serves an urban territory with a population of 22,000.

Staff: The staff consists of one supervising nurse, and a part-time visiting housekeeper.

Time of Work: Supervising nurse gives prenatal care; makes at least one call upon each baby whose birth is recorded with the city clerk. If necessary, makes further calls, giving mother advice as to care and feeding. Maintains a weighing station and keeps accurate record of weights and measurements. Conducts two kindergarten classes each week (one colored) and supervises work in Mothercraft among the older girls. Assists at the Tri-County Orthopedic Clinic conducted by the state and attends to follow-up work. Conducts a well baby conference twice a month under the direction of a local physician. Visiting housekeeper gives advice and demonstration in housekeeping and food preparation.

Financial: Budget for 1923 was \$5,000. This was obtained by membership dues, an appropriation from the city, and the annual drive.

General Statement: The Child Welfare Society is one department of the Freeport Civil Center which includes the health and social agencies of the county.

INDIANA

Elkhart

CHILD WELFARE STATION, CHILD WELFARE DEPARTMENT OF THE ELKHART CHAPTER,
INDIANA LEAGUE OF WOMEN VOTERS

Organized September 14, 1920.

Aim: To reduce infant mortality rate and increase health of the coming generation by teaching the mother how to keep her child well.

Board: The governing board consists of 10 women.

Territory: The Station serves an urban territory with a population of 35,000. There are eight sub-stations.

Staff: The staff consists of a director of medical service, 2 doctors, part-time (volunteer), 1 director of nursing service, 1 staff nurse, 1 director of nutrition, 1 part-time nutrition worker, 12 volunteer workers.

Type of Work: Educational and preventive work is done through home visiting for prenatal, infancy, and pre-school care and a health center for infants and pre-school children.

Financial: Supported by an appropriation from the Community Chest. Total budget \$6,500.

General Statement: The cooperating agencies are the Associated Charities, City Health Department, Mother's Club, Indiana League of Women Voters, Indiana Division of Infant and Child Hygiene and the Red Cross.

RED CROSS PUBLIC HEALTH NURSING BUREAU

Organized October, 1919.

Aim: To teach the community that disease can be prevented by intelligent living and care of the body.

Board: Governing board consists of the officers and executive committee of the Elkhart Chapter of the American Red Cross.

Territory: The territory covers Elkhart City with a population of 35,000.

Staff: The staff consists of 1 supervisor, 3 nurses, 1 social worker and executive secretary. Volunteers: 1 nurse, 1 social worker (part-time).

Type of Work: Prenatal, obstetrical, postnatal, pre-school, school nursing, tuberculosis nursing, bedside care; classes in home hygiene and care of the sick taught in health center. Health center furnishes health information and literature free of charge.

Financial: Community Chest, Red Cross membership, nursing fees and a per cent of all Tuberculosis Society Christmas Seals sold in Elkhart City. Chairman and treasurer of Red Cross chapter are held responsible for handling the finances.

General Statement: Nurses personally carry to every prenatal case the best literature issued by the United States Government, State of Indiana, and other health organizations. Every expectant mother reported to our office is visited regularly. Home visits are made to school children in whom physical defects are found. Medical and dental care is furnished free to children unable to pay through co-operation of school board and men's clubs. Bedside care furnished to the public free to those who cannot pay, 75 cents per hour to those who can. Trained nurse furnished for confinements in the home at a charge of \$5 for four hours or less:

75 cents per hour for each additional hour: service free to those unable to pay. Every tuberculous patient reported by doctor or health officer visited twice every month or more often if needed.

Evansville

BABIES' MILK FUND ASSOCIATION

Organized: 1912.

Aim: Infant welfare including prenatal, postnatal and pre-school care.

Board: The governing board consists of 5 men and 11 women.

Territory: The territory covered is both urban and rural with a combined population of 192,000.

Staff: The staff consists of an office secretary, a medical director, 20 doctors, part-time (free service), 2 obstetricians, and eye, ear, nose and throat specialist, and a skin specialist. Nursing staff: Supervisor and 4 nurses. Joint superintendent with Visiting Nursing Association.

Type of Work: Clinics are conducted for maternal, visual, and orthopedic cases, and health centers are maintained.

Financial: The budget for the year was \$13,471. The Association is financed by membership dues, appropriation from the city and county, and special contributions.

General Statement: During the year 4,544 patients visited the clinic, and 17,232 visits were made by the staff. Since January 1 there have been 116 prenatal cases, 69 deliveries, 1 stillbirth, 68 living babies, and 47 active cases.

Indianapolis

DIVISION OF CHILD HYGIENE, CITY BOARD OF HEALTH

Organized: 1922.

Aim: To do preventive and educational work in the interest of infants and pre-school children; also dental conservation work, largely among school children.

Territory: The Division serves an urban territory with a population of 350,000.

Staff: Nurses: 8. Physicians: 7, part-time. Dentists: 6, part-time. Dental nurses: 2.

Type of Work: Preventive and educational. Health center and home visiting for infancy and pre-school age. Dental clinics.

Financial: Funds are derived from taxation.

General Statement: The child health work formerly done by the Children's Aid Association is now carried on by the Division of Child Hygiene of the City Board of Health.

FAMILY WELFARE SOCIETY

Organized November 1, 1922.

Aim: Family work, child problems, home finding, child placing, unmarried mothers, juvenile welfare work.

Board: Governing board consists of 21 men and women.

Territory: The society serves an urban territory with a population of 350,000.

Staff: General secretary, case supervisor, director of the Children's Bureau, director of Social Service Exchange, and four supervisors, 18 field workers in the Service and Relief Department, 6 workers in the Children's Department, director of unmarried mothers' work, 11 clerical assistants.

Type of Work: The purpose is to carry out the objectives stated in the aims.

General Statement: The cooperating agencies are the Council of Social Agencies, Community Fund, Jewish Federation, Catholic Community Center, Public Health Nursing Association, Child Hygiene Division of the City Board of Health, Tuberculosis Society of Indiana, City Board of Health, State Board of Health and State Board of Charities.

PUBLIC HEALTH NURSING ASSOCIATION OF INDIANAPOLIS

Organized January 4, 1913.

Aim: To give skilled nursing care in the home, to teach hygiene and to prevent illness.

Board: The governing board consists of 24 women.

Territory: The Association serves an urban territory with a population of 350,480.

Staff and nurses: Superintendent, assistant, educational director, 3 supervisors, 20 field nurses, 5 student nurses; a physician in attendance at a general educational clinic held once a week for foreign patients; 4 nurses are trained for special care of crippled children in their homes. Clerical assistants 4. A number of auxiliaries make all the surgical dressings used. Two auxiliaries make and furnish the nurses' aprons and towels.

Type of Work: In addition to the regular visiting nursing, weekly clinics are held for diagnosis and disease prevention. Two health teaching centers are maintained. Two nurses, especially trained, are caring for crippled children in their homes. Efforts are being made to interest the proper authorities in establishing a special school for crippled children.

Financial: The Association is supported by membership dues, donations and the Community Chest for the free work. It also has paid service.

General Statement: The Health Teaching Center gives nine weeks' experience in all phases of public health nursing to senior students of accredited hospitals. Prenatal and postnatal nursing and educational work have increased 40 per cent. Home care for crippled children is given. The Public Health Nursing Association is doing a definite piece of work with children of pre-school age and is developing this project. In the Americanization work of the organization a nurse is assigned to the six kindergartens in which are the children of foreign parentage. She makes routine inspection in the kindergartens, calls on every child in its own home, takes the children for correction of defects to the dental clinics, the dispensary or hospital. She sees that every child receives toxin-antitoxin and smallpox vaccination.

In the work with crippled children a special effort is made to locate the child under six. Most of these are found by the nurses in their regular rounds. The majority of small children are not under the care of an orthopedic surgeon when found. They are taken to the orthopedic clinics, are examined, treated and furnished with braces when necessary, and are visited frequently in the home. Massage and muscle manipulation are given by the nurse when so ordered.

Pre-school children in a home visited by a Public Health Association Nurse are inspected and referred to dispensaries or private physicians when necessary.

South Bend

CHILDREN'S DISPENSARY AND HOSPITAL ASSOCIATION

Organized May, 1909.

Aim: To dispense free treatment to children under 16 years of age whose parents are unable to pay a physician's fee; also, free treatment to prospective mothers.

Board: The governing board consists of 24 women.

Territory: The territory covered is urban with a population estimated as 100,000.

Staff: Superintendent, doctors 14 part-time (free service); nurses 3; dentists 6 part-time (free service); social worker, 1 part-time (free service), the remainder of the social service work is carried on by the nurses; clerical assistants, 4 part-time; volunteer workers 12 part-time.

Type of Work: Home visiting and clinical service offered to prenatal, obstetrical and postnatal patients, infants and school children. Surgical service for eye, orthopedic and dental patients.

Financial: The Association is supported by the community chest.

General Statement: The Association cooperates with other agencies interested in child welfare. A special feature of the work is the orthopedic posture clinic, which is supported by a separate fund provided by a member of the board. Through the cooperation of the Y. M. C. A. and Y. W. C. A. directors who attend the clinics, the children receive the necessary corrective exercises.

IOWA

Des Moines

IOWA TUBERCULOSIS ASSOCIATION

Organized 1915.

Aim: The promotion of public health with special reference to tuberculosis.

Board: The Association is governed by a board of directors, 25 of whom are appointed at large and the remainder elected or appointed by county and local associations as their representatives.

Territory: The work of the Association covers the state, with a population of 2,403,603.

Staff: Executive secretary. Doctors: 2 part-time. Nurses: 1 supervising, 1 staff. Director of school health and modern health crusade. Secretary for legislative and organization work. Clerical assistants: 4.

Type of Work: The work of the Association is educational and preventive. The Modern Health Crusade was conducted in the schools. Literature and exhibit material was distributed and health news and feature articles were furnished the newspapers regularly. Films were loaned speakers and clinicians. Staff nurses were furnished and tuberculosis clinics were conducted. Nurses' supplies and school scales were also distributed. During the year the Association distributed 1,200,000 pieces of literature, helped securing the passage of 19 important health measures and wrote the Physical Educational Bill which is now a law. The Association co-operates with the State Department and private organizations interested in health

sanitation, and child welfare. The Association is distributor of Christmas Seals for the state. It has an agency for a number of the American Child Health Association's publications and other health literature and issues a monthly magazine.

Iowa City

IOWA CHILD WELFARE RESEARCH STATION

Organized 1917.

Aim: Investigation of the best scientific methods of conserving and developing the normal child, the dissemination of the information by such investigation and the training of students for work in such fields.

Board: There are 4 men and 2 women on the governing board. There is also an advisory council consisting of 6 men.

Territory: A population of 2,500,000.

Staff: Director, research professor, 2 associate research professors, assistant research professor, 3 research associates, 6 research assistants, 8 graduate student assistants, 3 nurses, and 2 secretaries.

Type of Work: Research on the development of normal and superior children from birth through school age, including particularly nutrition, physical growth, mental development and social development.

Financial: The Station is supported by the state and special funds from organizations, including the Laura Spelman Rockefeller Memorial. The budget for the year is \$55,000.

General Statement: The purpose of the Station is to develop practical methods of child rearing, modified to suit the varied needs of child life and to give to parents dependable counsel to insure the continuous improvement of every child to the maximum ability consistent with its native endowment and special abilities.

The point of view and methods of the Research Station are those of the natural and applied sciences, where a limited number of problems are investigated with the conditions standardized so that the experiments may be repeated, controlled, and modified. The Station performs three closely interrelated functions as provided by law: investigation of the best methods of conserving and developing the normal child, training of research students, and dissemination of information obtained through research.

SCHOOL OF PUBLIC HEALTH NURSING

Organized 1920.

Aim: Through supporting the public health nursing of the county, to establish field work of great excellence for the student nurses.

Territory: The territory served is both urban and rural with a population of 15,000.

Staff: 1 nurse in country, 2 nurses in city, 1 Hospital Social Service.

Type of work: Generalized program.

Financial: Funds are derived from the State University of Iowa. Budget for field work about \$7,500.

General Statement: The work in the city includes parochial schools (600 children) and Metropolitan Life Insurance Company industrial policy holders. In the country there is generalized work emphasizing school phases.

KANSAS

Manhattan

CHILD WELFARE AND NUTRITION CLINIC, DIVISION OF HOME ECONOMICS, KANSAS
STATE AGRICULTURAL COLLEGE

Aim: The purpose of the Child Welfare and Nutrition Clinic, held weekly in the Division of Home Economics at the Kansas State Agricultural College, is to keep well babies well.

Program: Weekly baby clinics for examination and supervision of all children of pre-school age. Talks and demonstrations for mothers. Home visits by members of the staff.

Staff: Nurse, nutrition worker, teaching fellow.

Plant: The plant consists of two rooms on the first floor of Home Economics Hall. The rooms are steam heated, and a toilet and running water is accessible. There is a waiting room and a weighing and measuring room.

Clinic routine: Each mother is required to secure for her children physical examinations from her family physician in order that the clinic may cooperate with him.

1. Each babe or child undressed and weighed.
2. Conference with graduate nurse. Histories of all new cases are taken and entered on chart. Literature is distributed.
3. Conference with nutrition worker if indicated.

Wichita

PUBLIC HEALTH NURSING ASSOCIATION

Organized February, 1919.

Aim: To benefit those otherwise unable to secure skilled assistance in time of illness; to promote cleanliness and to teach proper care of the sick; and to establish and maintain one or more hospitals for the sick, or a home or homes for the accommodation or training of nurses.

Board: The governing board consists of 16 men and 11 women.

Territory: The Association serves both urban and rural territory with a total population of 82,128.

Staff: Doctors: 9 part time (6 of whom are volunteers). Nurses: 1 director, 1 supervisor, 15 staff. Clerical assistants, 2.

Type of work: A great deal of preventive work is done. Home visiting, clinics, and hospital care are provided for expectant mothers, infants and children. Health centers are maintained. Maternity service day and night.

Financial: The total budget for the year was \$25,000. The Association is supported by membership dues, contributions, appropriations, Community Chest and fees.

General statement: Total visits made by staff Jan. 1 to Sept. 1, 1924, 25,094.

KENTUCKY

Louisville

PUBLIC HEALTH NURSING ASSOCIATION

Organized January, 1920.

Aim: To provide skilled nursing care for the sick in their homes and to decrease infant mortality.

Board: The governing board consists of 4 men and 26 women.

Territory: The Association serves an urban territory with a population of 300,196.

Staff: Superintendent, educational director, 3 supervisors, 28 staff nurses, 3 clerical assistants; medical director and 10 assistants. 40 volunteer workers.

Type of work: Eleven infant welfare clinics are conducted weekly; Little Mothers' League classes are held for school children in the school. The Association cooperates with the City Hospital in conducting a prenatal clinic. Home visiting is an important part of the work of the Association.

Financial: The total budget for the year 1924 is \$60,548.38. The Association is supported by the Community Chest, city appropriations, fees, and an income from the Metropolitan Life Insurance Company.

General statement: During the past year the Association has supervised 4,168 babies. At the present time there are 2,872 enrolled. During the year 7,512 infant welfare clinics were conducted with an attendance of 11,824; 45,783 home visits were made to the babies. The infant mortality rate for infants under 1 year is 16.2 per 1,000, over 1 year 6.5 per 1,000. During the year 1,502 patients were given prenatal care; 6,254 home visits were made to these patients; 90 prenatal clinics were conducted at the City Hospital. Attendance, 2,801.

Out of 1,502 prenatal patients, 495 were given postnatal care by the Association. There were 3,961 postnatal visits made, 318 patients were delivered in hospitals, and 12 by midwives. There were 20 miscarriages. Of the total number of patients under supervision during the year, there were 8 maternal deaths and 43 infant deaths, at the time of delivery.

LOUISIANA

New Orleans

CHILD WELFARE ASSOCIATION OF NEW ORLEANS

Organized May, 1913.

To secure adequate medical and nursing care for every member of every family in need of such care.

Board: The governing board consists of 19 men and 8 women.

Territory: The Association serves an urban territory with a population of 385,000.

Staff: Executive; director of infant welfare; director of maternity service.

Doctors: 9 part time. Nurses: 1 supervisor, 28 staff. Dentists: 1 supervisor, 2 part time. Clerical assistants: 4. Volunteer workers: 208.

Type of work: Clinics are held for infants, pre-school children, prenatal, obstetrical, and postnatal patients. Home visiting is another phase of the work.

Financial: The budget for the year was \$62,000. The Association is supported by membership dues, appropriations from the city and state, special contributions, and fees.

General statement: During the year the maternity service gave complete care to 550 cases, visiting nurse care to 2,140 adults and infant welfare supervision to 7,428 children. In addition to the usual obstetrical nursing care supplied to patients with private physicians, the Child Welfare Association also maintains a maternity service by which both physician and nurse are supplied. Patients registering for this service are charged a fee that ranges from \$15 to \$25 according to income. In this, as in other branches of the service, a separate staff of negro nurses and negro physicians, under white supervision, is maintained to care for the negro patients.

MAINE

Augusta

MAINE PUBLIC HEALTH ASSOCIATION

Organized July 13, 1921. (Formerly Maine Anti-Tuberculosis Association.)

Aim: To foster and promote education in all matters pertaining to public health; to distribute literature on public health; to employ public health nurses to cooperate with the State Departments of Health and State Department of Education and all other institutions and associations actually engaged and interested in educational and public health work; to form local public health associations; to conduct an educational campaign in all phases of public health activities; and to take and hold by purchase, gift, devise or bequest personal or real estate, in all not exceeding in value one hundred thousand dollars owned at any one time and to use and dispose of the same for the above named purposes.

Board: There are 36 persons on the governing board.

Territory: The work of the Association covers the State with an urban population of 145,232 and a rural population of 622,764.

Staff: The staff consists of an executive, 20 part-time doctors (volunteer), 1 director of nurses, 4 field nurses, 1 supervising dentist, 15 part-time dentists (volunteer), 1 field director for the Modern Health Crusade, 2 clerical assistants and 10 volunteers.

Type of work: The work includes clinics and home visiting for maternal, prenatal, infancy, pre-school, school and adult groups; classes and health centers for maternal and prenatal groups.

Financial: Budget for 1924 was \$25,000. The organization is supported by membership dues, contributions, and seal sale.

General statement: The cooperating agencies are the Associated Charities, State Parent-Teachers Association, Granges, Federation of Women's Clubs, Maine Medical Society, Maine Dental Society, Associated Industries, State Nurses' Association, and State Teachers' Association. All medical policies are supervised by an Advisory Committee named by the Maine Medical Association. The same committee serves the Maine Medical Association as its committee on Public Relations. The Personnel of the committee includes a president, a secretary of the Maine Medical Association, the editor of the Journal of the Maine Medical Association, and three medical members of the Executive Committee and the State Commissioner of Health.

In carrying out this policy of cooperation with the medical profession the county medical societies in practically every Maine county have named similar committees which serve the volunteer health association in the county as a Medical Advisory Committee. This county committee usually includes the doctor most active in volunteer health work, the secretary of the County Medical Society and the District or County Health Officer.

Portland

PORTLAND BABY HYGIENE AND CHILD WELFARE ASSOCIATION

Organized June, 1919.

Aim: Maintenance of a day nursery, milk station and clinics for children, home hygiene instruction, and introduction of nutrition work in public schools.

Board: The governing board consists of 25 women.

Territory: The city with a population of 70,000.

Staff: Executive. Doctors: 10 part-time (volunteer). Nurses: 1 supervisor. Nutritionists: 1 supervisor, 1 full-time, 1 part-time. Dentists: 16 part-time (volunteer). Clerical assistants: 1. Volunteers: Junior League.

Financial: The Association is supported by special contributions.

MARYLAND

Baltimore

THE BABIES MILK FUND ASSOCIATION

Organized 1904.

Aim: Educational and preventive work.

Board: The board consists of 16 men and 28 women.

Territory: The Association serves an urban territory with a population of 765,554.

Staff: Medical director, executive secretary, assistant superintendent of nurses, 1 supervisor, 28 staff nurses, and 11 part-time physicians.

Type of work: Home visits by nurses, 43 conferences during week held at 20 centers, including prenatal, infant and pre-school welfare.

Financial: The budget for the year was \$53,601. The Association is a member of the Baltimore Alliance.

General statement: The number of patients given home care during the year was 10,510; the number of home visits paid 72,593; the number of patients who visited the clinics 27,877.

FLORENCE CRITTENTON MISSION, INCORPORATED

Organized 1896.

Aim: To provide a home where unfortunate and wayward girls may receive proper care; be taught those things that are essential to their well-being, both cultural and industrial; and where under the influence of Christian example and teaching they may be helped to return to normal relations in society.

Board: The governing board consists of 11 men and 11 women.

Financial: The Mission is supported by dues, donations, and state appropriations.

General statement: Many of the girls coming to the Mission practically homeless, friendless and untrained, meet a spirit of sympathy and a helpfulness, which changes their entire outlook on life. The training which they receive in nursing, needlework, and household arts, equips them to earn their own living. The Mission also cares for the city's foundlings. Due to the scientific treatment and careful nurture which they receive, most of them grow into healthy babies and are adopted into good homes. The mortality rate is very low.

HEALTH DEPARTMENT, BUREAU OF CHILD WELFARE

Organized February 1, 1919.

Aim: Promotion of health and conservation of lives of mothers, infants and young children.

Board: The Bureau is a sub-department of the Department of Health of Baltimore City.

Territory: The Bureau serves an urban territory with a population of approximately 773,580.

Staff: Director, with 1 assistant and office force (4); obstetricians: 1 full-time, 3 part-time; pediatricists: 4, part-time; nurses: 23 field, 1 social service, 3 obstetrical.

Type of work: Prenatal clinics for expectant mothers (4), obstetrical care in home; postnatal care of mother and child; welfare clinics for the pre-school child from birth to school age; dispensary for sick children; day nursery for colored children. Nurses visit every newborn baby, mothers are instructed, care secured for sick children, boarding homes supervised, instructive leaflets, birth certificates, weight and height cards distributed.

Financial: The budget for the year 1924 was \$74,880 (including nurses' salaries).

General statement: The plan of work for the year 1924 includes the establishment of 5 additional pre-school conferences. It is hoped that in the near future a maternity hospital may be established in the city and the present plan of prenatal clinics extended to cover the entire city; also that a clinic for sick children can be established in the southeastern section of the city.

HENRY WATSON CHILDREN'S AID SOCIETY

Organized 1860.

Aim: To place homeless and destitute children in family homes.

Board: The governing board consists of 24 members.

Territory: The Society serves an urban population of 733,826.

Staff: There are 28 members of the staff, including executive and stenographers.

Type of work: Child placing.

Financial: Funds are derived from income from endowment, state appropriation, individual contributions, board from guardians and wards, and allowance from Financial Federation.

JEWISH CHILDREN'S BUREAU

Organized January, 1914.

Aim: Close cooperation among the organizations working for the welfare of the Jewish children of Baltimore.

Board: The governing board consists of 19 members.

Territory: The city of Baltimore.

Staff: Executive Secretary, psychiatrist, vocational director, visitor and stenographer.

Type of work: Preventive and educational. Home visiting for pre-school and adolescent ages. Research on adolescence, dependent children and special work.

Financial: Budget, \$9,500. The bureau is a constituent member of the Associated Jewish Charities.

General statement: The bureau includes two members (the social worker, and a member of the Board of Directors) from each of the 9 constituent organizations, and the executive secretary of the board. The bureau has original jurisdiction over children in behalf of whom application is made for institutional or boarding care, children who have to be treated apart from their families and abandoned children. The bureau does the psychiatric work for Jewish children and conducts a vocational bureau.

MASSACHUSETTS

Boston

THE BOSTON FLOATING HOSPITAL—ON-SHORE DEPARTMENT

Organized July 1, 1894.

Aim: To care for and relieve the sick babies of parents, unable to provide the best air, food, care and medical skill; to make a careful scientific study of the diseases of children, especially those connected with the gastro-intestinal tract; to train and instruct medical students, nurses and mothers in the care and treatment of sick babies.

Board: The Hospital is governed by a board of 15 men.

Territory: The entire City of Boston is served as well as other localities.

Paid staff: Resident physician. Superintendent of nurses. Technician in X-ray and physiotherapy. Nurse for X-ray Whooping Cough Clinic and home visiting. Bacteriologist. Three full-time nurses in well children's clinics. One secretary. One assistant on clinic days.

(The Hospital has also a full staff of visiting and consulting physicians, who give their services voluntarily, as well as twelve internes during the summer.).

Financial: The budget for the year was \$95,916.98. The hospital is supported by voluntary contributions and the figures given cover the cost of the Floating Hospital as well as the On-Shore Department.

General statement: The Hospital Boat is in commission from June 27 to September 15, and makes daily and nightly trips out in the Harbor.

Approximately 300 children from 4 weeks to 5 years of age enrolled in Well Children's Clinic.

Two Clinics are held weekly and each child has its temperature taken on each visit, and is seen by one of the staff physicians. Whooping Cough Clinics are held

3 days a week; children are brought for treatment in a motor conveyance owned by the Hospital. 283 children received treatment and follow-up work at the Whooping Cough Clinic during the past year.

Ultra-violet, and deep ray therapy used 3 days a week for children with rickets and tuberculosis, and diathermy for bronchial conditions. (The majority of the physiotherapy cases are children who had heliotherapy, on the Boat during the summer.)

A small ten-bed ward is maintained with six nurses in attendance for the treatment of infants acutely ill, and for the metabolic studies of various foods, especially dried breast milk.

BOSTON SCHOOL OF PHYSICAL EDUCATION

Organized September, 1913. Incorporated 1914.

Board: Directors 3, corporation members 20, teachers 18.

Staff: There are 17 on the faculty.

General statement: At present the School offers a two year course in physical education. Commencing September, 1925, the course will be three years except in the case of certain college graduates who from their preparation seem equipped to take the course in two years.

A course on Psychology and Health is given three hours per week, running through the year, each quarter's work being organized around a particular topic.

COMMUNITY HEALTH ASSOCIATION

Organized December 29, 1922, when persons designated by the Board of Managers of the Instructive District Nursing Association and by the Board of Trustees of the Baby Hygiene Association constituted a joint managing committee to supervise the conduct of the work of each Association in cooperation with that of the other.

Aim: To direct the management of the work of the Instructive District Nursing Association and of the Baby Hygiene Association, subject always to the Board of Managers of the Instructive District Nursing Association and to the Board of Trustees of the Baby Hygiene Association, to the end that through a joint management the work of each Association, while remaining the separate work of that organization, might be conducted in such cooperation with the work of the other organization that increased economy and efficiency of operation could be effected.

The stated purposes of the two organizations have been greatly amplified and extended during the course of development of each. The Instructive District Nursing Association was established 38 years ago to give nursing care and instruction to the sick poor.

The Baby Hygiene Association was established 15 years ago to encourage breast feeding; to provide pure milk properly modified for babies who cannot be nursed; to furnish mothers advice and training in hygiene and care of babies, and to assist in improving the general milk supply.

The ideals of the two were the same—to bring facilities for health to the families in which the public health nurses work. Their natural development has tended to make their objective identical—to raise the standard of health in every family they serve.

Board: The governing board consists of 33 members, with 5 additional members ex officio.

Territory: Metropolitan Boston.

Staff: The staff consists of 30 doctors, 111 nurses, including the General Director, the directors of individual departments, supervisors and staff nurses, 6 nutrition workers, 27 office workers, 3 in the mental hygiene department.

Type of work: The Association offers the following health services: Bedside nursing and health teaching, prenatal, care at confinement, postpartum, well baby, pre-school, orthopedic (including after care of poliomyelitis chronic cases and posture work), nutrition, mental hygiene, care of communicable diseases, excepting scarlet fever and diphtheria, industrial nursing.

The Board of the Community Health Association has adopted the policy that each nurse shall perform as many types of nursing service in a home as are practical without impairing the efficiency of the work, and that experts in special subjects are necessary and shall be employed to carry out this policy.

Financial: The Association is financed by voluntary contributions, and payments for services rendered.

The work of the Association has been cut to meet a reduction of \$130,000 in the budget, the reduction to be spread over a period of 16 months. It is hoped that the financial organization will justify an increase in expenditures after that time.

The program for 1925 includes all services enumerated above, maintaining one demonstration area and curtailing the work to fit the capacity of the reduced staff by discontinuing all services in certain areas and giving general publicity to the reason for closing local centers.

In the coming months the best efforts of the Association are to be put into financial organization. The health program will be developed in so far as the financial organization becomes a reliable instrument for its support.

DEPARTMENT OF PUBLIC HEALTH, THE COMMONWEALTH OF MASSACHUSETTS

The Massachusetts Department of Public Health, so far as its Division of Hygiene is concerned, is an advisory body. It does no case work in the ordinary sense of the word; consequently its activities are largely educational in character and have for their purpose the encouragement of new work on the part of the different municipalities of the state. Outstanding activities are:

1. Extension of work for the promotion of maternal and infant hygiene.
2. Cooperation with the Division of Tuberculosis in Examination clinics for underweight school children for the purpose of detecting or preventing hidden tuberculosis.
3. Regional conferences on maternal and child hygiene.
4. Courses in nutrition for school nurses.
5. Conferences for school physicians, nurses, school superintendents, and others interested in the medical supervision of the school child. These conferences are participated in by the State Department of Education.
6. Wide extension of newspaper and other health education service.
7. Summer course in school nursing in cooperation with the State Department of Education; also one in cooperation with Simmons College.

FORSYTH DENTAL INFIRMARY

Aim: Dental, medical and surgical treatment to relieve and improve the teeth of the children.

Board: The governing board consists of 11 members.

Territory: The city of Boston.

Type of work: Preventive and educational. Clinics and hospital dental service for infancy, pre-school and school ages.

Financial: Budget \$94,000. Supported by endowment.

MASSACHUSETTS PARENT-TEACHER ASSOCIATION, INC.

Organized 1910. Incorporated 1920.

Aim: To promote high standards of home life and cooperation between parents and teachers in order to secure the best physical, mental and moral development of the child.

Board: The governing board is composed of 3 men and 22 women.

Territory: The Association covers the entire state in its work.

Type of work: By forming, guiding, and binding together local associations, it promotes the study of the child, a knowledge of existing conditions in home, school, and community, and stimulates constructive work to meet the needs of the children.

General statement: The Association has 13,000 members in 170 local groups, some in cities, some in towns, some in small rural communities. It is a branch of the National Congress of Parents and Teachers whose membership is 700,000.

A great effort is made to encourage training for the home and for parenthood. At the suggestion of the Massachusetts Parent-Teacher Association, a university extension course for parents of pre-school age children was established in 1923 by the Massachusetts Department of Education. In July, 1923, the first Parent-Teacher Summer Schools in Massachusetts were held at Hyannis and at Boston University. In 1924 summer institutes were held at three State Normal Schools, North Adams, Fitchburg and Hyannis.

MASSACHUSETTS TUBERCULOSIS LEAGUE, INC.

Organized 1914.

Aim: To conduct a persistent campaign against tuberculosis in the state of Massachusetts by the initiation, stimulation, and promotion of work in every field which concerns the eradication of the disease.

Board: There are 52 men and 25 women on the governing board.

Territory: The League serves an urban territory of four million population.

Financial: The budget for the current year is \$58,191. Funds are derived from seal sale percentage and membership.

General statement: The program of the League and its 27 affiliated organizations stresses child health work and especially child health education. It attempts to carry in stock samples of all best educational material published and to handle in quantity that which is most popular. Through its district workers who cover the state it has contact with the schools, especially through school nurses. It is co-operating with the State Department of Health in a campaign for the examination of all underweight school children to discover all those inclined to tuberculosis and to give them such remedial attention as may be necessary in order to build them up so that they will never be in danger of breaking down with the disease.

NEW ENGLAND DAIRY AND FOOD COUNCIL

Organized August, 1920.

Aim: To increase the consumption of milk through the education of children and adults.

Board: The governing board consists of 9 men.

Territory: The territory served is urban, including Greater Boston, Providence and Worcester.

Staff: Managing director. Man for exhibits. Office clerks: 2. Nutrition workers: 3. School teacher. Errand boy.

Type of work: Educational work on nutritional and health value of milk and its proper place in the diet of the people.

Financial: The budget for the current year is \$56,000. Funds are derived from the dairy industry (milk producers and distributors) and Massachusetts Agricultural College.

General statement: Lectures and stories are given to schools, teacher training groups, women's clubs, school nurses, welfare workers, etc. Dramatics are given before school groups and parents' meetings. Health aids in leaflets, posters, etc., are distributed for use by health teachers.

Cambridge

WARD IV INFANT WELFARE COMMITTEE OF CAMBRIDGE

Organized October 1, 1914.

Aim: To further the health of babies and children in Ward IV, Cambridge. (Other wards are cared for by the city.)

Board: The governing board consists of 11 members.

Territory: The committee serves an urban population of 9,780.

Staff: Nurses: 2 full-time.

Type of work: Infant and pre-school clinics, home visiting.

Financial: Budget approximately \$1,900. The Cambridge Visiting Nurse Association pays one-half expense of nurses. The general public gives the balance.

General statement: This clinic was started to demonstrate the need of infant welfare work and continued for intensive work. It was not given over to the city because the committee wished to start a pre-school clinic and felt that two lines of work would make a more complete demonstration.

Fall River

MATERNAL AND CHILD WELFARE COMMISSION

Organized February, 1923, as Infant Welfare Commission. Became Maternal and Child Welfare Commission, a separate City Department by legislation, April, 1924.

Aim: To conserve the health of infants, prevent illness or death and promote health among mothers of infants and children of the pre-school age and babies in the city of Fall River.

Board: The Commission consists of 5 doctors.

Territory: 4 city wards.

Staff: Pediatricians, 2. Obstetricians, 3. Nurses: supervisor, 8 staff. Clerical Assistant, 1.

Type of work: Preventive and educational work is carried on through home visiting. Clinics for pre-natal, infancy and pre-school children, classes in pre-natal care called "Mother's Club."

Financial: Supported by appropriation from the city. Budget for 1924 \$26,000.

Falmouth

FALMOUTH NURSING ASSOCIATION, INC.

Organized May 25, 1916.

Aim: The prevention of disease and the promotion of health in the community.

Board: The governing board consists of 1 man and 11 women.

Territory: Rural territory is covered.

Staff: The staff consists of an executive (volunteer), 1 supervising nurse, 1 general nurse, 2 part-time dentists, and 1 clerical assistant.

Type of work: Home visiting for maternal, prenatal, obstetrical, and postnatal cases, infants, and pre-school children. Clinics are conducted for school children for the care of visual, dental, mental diseases and tuberculosis. A health center is maintained for school and adolescent children.

General statement: The Association cooperates with the Board of Health, Barnstable County Sanatorium, and Society for Prevention of Cruelty to Children.

Fitchburg

VISITING NURSE ASSOCIATION

Organized 1913.

Aim: Nursing the sick is the primary function of the Association.

Board: The Association is governed by a board of 13 men and 10 women.

Territory: The Association serves an urban territory with a population of 41,000, also two adjoining towns with school nursing.

Staff: Superintendent, 1 maternity nurse, 1 school nurse, 8 staff nurses, 1 doctor, part-time, and 1 clerical assistant.

Type of work: Home visiting, particularly for mothers and infants, is the chief work of the Association. Clinics for infants are also held.

Financial: The budget for the year was \$19,206.30. The Association is supported by contributions and subscriptions.

General statement: The nurses of the Association do generalized nursing. They visit the sick; give prenatal and postnatal care; make baby hygiene calls; give first aid in three industrial plants and one nurse gives maternity delivery care night or day. One nurse spends four days a week in two adjoining towns doing school nursing. One home hygiene class taught in high school. Four baby hygiene clinics held weekly. One nurse part-time in High School.

Holyoke

HOLYOKE CHILD WELFARE COMMISSION

Organized April, 1911.

Aim: To carry on preventive and educational work.

Board: The governing board consists of 3 men and 3 women.

Territory: The Commission serves an urban territory with a population of 65,000.

Staff: The staff consists of a medical director, 3 doctors, part-time, a supervising nurse, a prenatal nurse, a milk station dietitian, 2 assistants and 2 volunteer workers.

Type of work: Child welfare center and milk station dispense whole and modified milk daily which consistently runs below 10,000 bacteria per c.c. Home visiting, clinics and hospital care are offered to prenatal, obstetrical and postnatal patients, as well as to infants and pre-school children.

Financial: Appropriation \$20,282.50. Receipts \$12,618.00. Expenditures \$21,405.07. The Commission is supported by the city.

General statement: Infant Welfare: 5,213 home visits were made on 863 babies, and 1,415 babies were brought to clinics. Prenatal: 2,685 visits were made on 575 patients and 517 attended clinics. There were 363 deliveries and 340 mothers nursed their babies. Pre-school: 58 children were given care.

New Bedford

INSTRUCTIVE NURSING ASSOCIATION

Organized 1891. **Incorporated** 1900.

Aim: To care for the sick, to prevent disease and to promote health.

Board: The governing board consists of 14 women.

Territory: The Association provides a visiting nursing service for the city of New Bedford with a population of approximately 25,000.

Staff: Superintendent, assistant superintendent, supervisor, 11 staff nurses, registrar, 10 volunteer workers.

Type of work: General bedside nursing including the care of maternity patients and those with the so-called minor communicable diseases. Home visiting and mothers' classes for prenatal patients.

Financial: The budget for the year is \$29,900. This amount is obtained from fees paid for nursing service, the Community Welfare Fund and special contributions and the income from invested funds.

General statement: The Association planned to organize clinics for children of pre-school age as a part of the community health program recommended last year in the survey made by Dr. C. E. A. Winslow, but the Budget Committee of the Central Council of Social Agencies was obliged to cut off this item of new work in the budget submitted.

NEW BEDFORD CHILDREN'S AID SOCIETY

Organized 1842.

Aim: To care for destitute, neglected, and wayward children of either sex and of any race or creed, by providing them so far as possible with close supervision in selected family homes.

Board: The governing board consists of 21 women.

Territory: The Society serves both urban and rural territory. The population of New Bedford is 131,000.

Staff: A general secretary and a supervisor. Visitors: 5. Clerical assistants: 4.

Type of work: The Society furnishes supervision and care for both unmarried mothers and children.

Financial: The total budget for the year was \$46,614.25. The Society is supported by membership dues, contributions, community chest and fees.

General statement: The total number of children cared for during the year was 281.

Newburyport

NEWBURYPORT HEALTH CENTER

Organized July 1, 1920.

Aim: Health work.

Board: The governing board consists of 15 members.

Territory: The Center serves an urban population of 16,000.

Staff: Nurses, 3; 1 half-time pupil nurse.

Type of work: Child welfare, tuberculosis, district nursing, Red Cross home service.

Financial: Funds are derived from the Anti-Tuberculosis Association, Red Cross, Moseley Foundation and private donations. The budget for the current year is \$7,400.

General statement: Conferences are held weekly for child welfare; 2 clinics are held weekly for tuberculosis; home visiting is a part of both of the preceding lines of work. District nursing is included in the program. Red Cross home service work and classes in "Home Hygiene and Care of the Sick" are given by the Red Cross. Dental work for the pre-school child is offered one afternoon a week. A mental clinic and an infantile paralysis clinic are held in the rooms of the Center although not a direct part of the work.

Springfield

VISITING NURSE ASSOCIATION

Aim: To promote the health of Springfield. It seeks not only to alleviate suffering by skilled bedside nursing, but to teach preservation of health by instruction to families in the simple rules of nursing and hygiene.

Board: The governing board consists of 8 men and 17 women.

Territory: The Association serves the city of Springfield with a population of 135,000.

Staff: Director, medical director, 11 doctors (volunteer), 1 general supervising nurse, 19 staff nurses, 2 clerical assistants.

Type of work: Bedside nursing, Metropolitan Life Insurance nursing, infant and child welfare education, prenatal care, delivery service and postnatal care, industrial nursing, occupational therapy, and operations in the home. It also conducts 1 prenatal clinic, and 9 child welfare clinics.

Financial: The organization is supported by fees collected, Metropolitan Life Insurance Company, and Community Chest.

Worcester

WORCESTER SOCIETY FOR DISTRICT NURSING

Organized 1892.

Aim: Home nursing, public health.

Board: The governing board consists of 14 directors, 7 advisory.

Territory: An urban and rural population of 100,000.

Staff: Superintendent, chief supervisor, 4 supervisors, 40 staff nurses, 3 clerical workers.

Type of work: Nursing care in the home, teaching families simple rules of nursing and hygiene.

Financial: The society is supported by invested funds and the Community Chest. Budget \$60,000.

MICHIGAN

Detroit

BABIES MILK FUND OF DETROIT

Organized 1906.

Aim: To conduct a prophylactic clinic and follow-up work.

Board: The governing board is composed of 4 men and 15 women.

Territory: Both urban and rural territories are served.

Staff: Doctors: 1 director, 2 part-time. Nurses: 1 superintendent, 4 staff.

Type of work: Home visiting and clinics for infants and children are conducted. Preventive, educational and cardiac care is given.

Financial: The Association is an auxiliary of the Visiting Nurse Association; the budget for 1923 was \$14,000. The Association is supported by the Community Fund.

General statement: There were 260 clinics held during the year, with an attendance of 5,330 patients. The clinic at Hamtramck has had an increased attendance since locating at the Tau Beta Community House. Some fifty or sixty day nursery children attend the clinic for regular weekly examinations.

CHILDREN'S HOSPITAL OF MICHIGAN

Organized in 1922. An amalgamation of the Children's Free Hospital Association, Detroit, and the Michigan Hospital School, Farmington.

Aim: To care and provide for sick, suffering or crippled children without discrimination as to race, creed, or color, and to furnish such medical, surgical, nursing, and educational aid as they may require; to maintain a training school for nurses; to establish and maintain such research and teaching facilities as are desirable for the development of medical and surgical science, and to do all things necessary or appropriate to such ends.

Board: The Hospital is governed by a permanent board of trustees of 39 men and women.

Territory: The Hospital serves the City of Detroit and does orthopedic work for the entire State of Michigan.

Staff: Superintendent and assistant with 2 instructors, 6 supervisors, 1 physiotherapist, 1 laboratory technician, 1 X-ray technician, 1 dietitian, 32 student nurses, 45 affiliated student nurses, 5 post-graduate student nurses, 1 pharmacist. **House staff:** 2 resident physicians and 6 internes. **Social service department:** director, secretary and 4 graduate assistants. **Medical staff:** consulting staff of 12 physicians and surgeons, an active staff with directors of department who have 35 associates and assistants.

Type of work: A general hospital for children caring for everything except contagious diseases, with a 100-bed convalescent home in Farmington. The medical staff holds weekly clinics for the discussion of important cases. The general staff and executive committee hold monthly meetings. The students of Detroit College of Medicine receive daily bedside instruction in the hospital. The medical staff devotes considerable time to lecturing to student nurses of the hospital.

Financial: The budget of the hospital for the current year was \$286,297. The hospital is supported by income from its endowment fund, and some contributions from the patients which amount to about 5 per cent of the expenses, and the deficit is made up by the Detroit Community Fund.

General statement: The Out-Patient Department continues to grow and widen its scope each year. Daily clinics are held in the medical, surgical and orthopedic departments and clinics four times a week in the various specialties. The social service department has been considerably enlarged and special workers are maintained for the orthopedic, cardiac, and chorea cases.

During 1924 the city hospital has been remodeled and improved. The Out-Patient Department has been rebuilt and a new waiting room has been added. This waiting room is furnished with steel and plate glass cubicles which provide privacy and prevent contact between waiting patients.

MERRILL-PALMER SCHOOL

Organized February 5, 1920.

Aim: The promotion and development of education in home making and child care.

Board: The governing board consists of 7 men and 6 women.

Territory: The school serves both an urban and a rural territory.

Staff: Director. Specialist in psychology, 2 assistants. Specialist in nutrition, 1 assistant and 1 field worker. Research specialist in nutrition and 1 assistant. Specialist in extension, 1 assistant. Nursery school teachers, 3. Supervisor of medical service. Registrar. Business manager. Clerical assistants, 3.

Type of work: General education in fundamentals of nutrition and courses in home making. Better methods of teaching child care and management are developed.

Financial: The budget for the year 1924 was approximately \$125,000. The School is supported by an endowment and a small tuition fee.

General statement: The School is developing programs of work, first, of an extension type which reach larger groups in the community, and second, of intensive character which in the beginning at least can reach only a limited group since the formulation of courses is one of the problems undertaken and this cannot be accomplished with large groups. New projects are a consultation center and research laboratory in the Children's Hospital.

Flint

DEPARTMENT OF HEALTH

Organized about 1915.

Aim: General health work.

Board: The governing board is composed of the Health Officer and 2 practicing doctors.

Territory: The territory served has an urban population of 137,398.

Staff: Full-time city physicians, 2; part-time physician ($2\frac{1}{2}$ hours daily). Registered nurses, 9. Laboratory technician. Clerks, 7. Dairy and Food Inspectors, 4. Sanitary Inspectors, 2. Plumbing Inspectors, 2.

Type of work: Home visiting, clinics, classes, hospital, health center.

Financial. The budget for the current year is \$73,661.

General statement: The Department consists of the following divisions which follow the usual standard procedure in each field:

Administration, Dental, General Clinic, Laboratory, Plumbing Inspector, Dairy and Food Inspector, Communicable Disease, Field Nursing, Sanitation, Vital Statistics.

Lansing

MICHIGAN DEPARTMENT OF HEALTH, BUREAU OF CHILD HYGIENE AND PUBLIC HEALTH NURSING

Organized September 15, 1920.

Aim: The aim of the Bureau is to reduce both maternal and infant mortality and morbidity in the state through education in prenatal and infant care; to demonstrate the value of public health nursing service throughout the state through an educational program and the development of community responsibility in health problems and the importance of local committees assuming the financing of such work.

Territory: Covers the entire state.

Staff: 1 director (doctor), 1 assistant director (nurse), 3 associate physicians, 10 staff nurses, nutrition worker, 2 clerks, 2 stenographers.

Type of work: Infant and prenatal clinics; establishment of mother and baby health centers; organization of county health committees and health center committees; education through classes in infant and prenatal care and the distribution of literature.

Financial: Amount of budget, \$64,482.22.

General statement: Much stress on prenatal care, care of pre-school child, breast feeding of infants, periodic or keep-well examinations, immunizing for diphtheria and smallpox, midwife inspection, and prevention of diarrhea and enteritis.

MINNESOTA

Duluth

SCOTTISH RITE INFANT WELFARE DEPARTMENT

Organized 1910.

Aim: The aim of the Masonic Infant Welfare Department is to keep well babies well. The work is purely educational. They try to lead the mothers to see the wisdom of preventive care, and also the immense value of early advice and a right start. They have no financial standard by which to determine the admissions to the clinics, all are welcome within the age limit, which is $2\frac{1}{2}$ years. The babies are registered, weighed, examined by a pediatrician, and advice given as to diet and general care. When the clinic children become ill or are in need of any special medical attention, they are immediately referred to their family physician and are not readmitted to the clinic until discharged by him. The Department cooperates with all the charitable organizations of the city.

Board: The Department is directed by the Scottish Rite Masons.

Territory: The work of the Department covers the entire City of Duluth, the population of which is 100,000.

Staff: Director. Doctors: Medical director, 2 part-time clinic physicians. Nurses: Supervisor, 2 assistant nurses. Volunteer workers: 11, part-time.

Type of work: Home visiting and infant welfare clinics. Work of nurse in home consists of advice and demonstrations (preparation of foods, etc.).

Financial: Financed by Scottish Rite Masons.

General statement: Five infant welfare stations are maintained. Clinics are held weekly at each station. Follow-up work is done by the nurses after each clinic. During the year 4,543 visits were made by the nurses, 883 new babies were admitted to the clinics, 4,684 were reexamined, and 96 were readmitted, which makes a total clinic attendance of 5,663. Outfits of children's clothing and layettes are made by the members of the Eastern Star to be distributed to needy families. Milk and prescriptions are also supplied to needy families. Literature pertaining to the care of the baby is distributed at the clinics.

During the year a breast milk dairy has been organized in connection with clinic work. The aim of the dairy is to procure breast milk that may be used in critical cases. The milk is expressed, pooled and sterilized at the clinic. It is secured free and will be given to any one not able to pay for it. This milk is especially valuable for weak or premature babies.

Minneapolis

DIVISION OF CHILD HYGIENE, STATE BOARD OF HEALTH

Organized July, 1922.

Aim: To promote the welfare and hygiene of maternity and infancy.

Board: Federal Board of Maternity and Infant Hygiene, 2 men and 1 woman. Minnesota State Board of Health, 8 physicians, 1 sanitary engineer.

Staff: Director, superintendent of public health nursing, 5 field nurses, 3 temporary field nurses, 1 vital statistics agent, 6 clerical assistants. Clinic physicians engaged as occasion demands, 1 special agent.

Type of work: Educational.

Financial: Budget for the year amounted to \$43,000. Supported by federal, state, and county appropriations.

General statement: The three large centers of population, Minneapolis, St. Paul, and Duluth, for several years have had facilities for carrying on maternal and infancy hygiene work and are not included in the work of the state. Close cooperation with state organizations and institutions, and the University Medical School in its Department of Obstetrics and Pediatrics and the Extension Division has lessened the difficulties of planning work to extend over a scattered population.

In organizing the State Board of Health, the State Board provided for the formation of a state advisory board on maternal and infant hygiene consisting of 4 men and 5 women, representing the organized medical and nursing professions of the state as well as the educational agencies and the organized women of the state. The duties of this Board are to advise and suggest in the administration of the Sheppard-Towner work in Minnesota and to secure cooperative action through the various agencies represented by its members. The first act of this Board was the creation of county administrative boards, consisting of 5 members which included the county health officer, county commissioners, a physician and two women to supervise the administration of the maternal and infant hygiene work in the counties, subject to the state and federal laws and the regulations of the State Board of Health. The most essential factor in the work of the Division is the cooperation of

physicians and the public health nurses of the state. Contact with the latter is secured and maintained through a superintendent of public health nursing and 3 field nurses working with the Division.

A series of 9 prenatal letters which have been adapted from those prepared by the United States Public Health Service, is being issued to expectant mothers. The first of these was sent out in February and to date (September 30) 3,000 have been mailed. A correspondence study course of 15 lessons has been prepared, which the Extension Division of the State University distributes through the regular channels. The course may be taken by any individual in the state free of charge, although there is a growing tendency for the organization of classes. Since the beginning of this course in February, 4,230 women have been enrolled.

The sterile obstetrical package, containing a minimum amount of material at an approximate cost of \$2, has also been prepared by the Division. After demonstrations throughout the state by the nurses, arrangements have been made for its sale, by groups of women, by the drug stores, or through the physicians. These packages are now available in 43 counties of the state.

A monthly news letter is circulated among public health nurses, physicians, and members of the county administration boards to stimulate uniformity of interest in the Sheppard-Towner act.

Outlines for a mothercraft course have been prepared and the necessary literature secured. A booklet for a course in mothercraft embodying infant and child feeding methods as taught in the Pediatric Department of the Medical School has been prepared. One edition has been exhausted and a second edition is being printed.

Demonstrations were held at 53 county fairs.

Demonstrations in the care and feeding of infants were given before the women of the Farm Bureau clubs in 27 counties. The Division has held 4 regular monthly prenatal clinics in different parts of the state.

A survey of the midwife problem has been completed, a report of which is now being prepared.

Two public health nurses of Indian blood, capable of talking the Indian language, are at work among the 13,000 Indians within the state. The project is financed by a gift from the American Child Health Association to match money available from federal funds.

INFANT WELFARE SOCIETY OF MINNEAPOLIS

Organized 1910. Incorporated 1913.

Aim: To provide medical supervision and nursing care for expectant mothers who cannot afford this service. To teach mothers the importance of breast feeding; to educate mothers to keep their well babies under the supervision of a doctor; to provide this supervision for mothers who cannot afford to pay for it. To teach mothers of children of pre-school age the proper feeding, environment and control of their children.

Board: The governing board consists of 8 men and 12 women, including the medical director of infant and pre-school work and the medical director of prenatal work.

Territory: The Society serves an urban territory with a population of 417,000.

Staff: Executive secretary. Doctors: 10, part-time. Nurses: 3 instructing, 14 staff. Clerical assistants: 2. Volunteer workers: 50. The students of the Home Economics Department of the University of Minnesota give part-time work in the pre-school department.

Type of work: Visits to the homes of all newborn babies to teach the importance of breast feeding, the value of regular medical supervision of the well baby and the necessity of a postpartum examination of the mother. Clinics for the well baby up to two years of age for those who cannot afford to pay for this service. Clinics and home follow-up work for expectant mothers and for children of pre-school age.

Financial: Total budget for the year 1923, \$40,475. The Society is a member of the Council of Social Agencies and is supported by the Community Fund.

General statement: The total attendance at clinics during the year 1923 was 19,925; visits made in the homes by the nurses, 31,301.

THE VISITING NURSE ASSOCIATION OF MINNEAPOLIS

Organized: The Association began as a Committee of the Associated Charities in 1904, and became incorporated as a separate organization in 1917.

Aim: To give skilled nursing care to residents of Minneapolis who are sick in their homes and to teach personal hygiene, cleanliness, prevention of disease and promotion of health.

Board: The Association is governed by a board of 6 men and 26 women.

Territory: Service is given the City of Minneapolis which has a population of 409,125.

Staff: Superintendent of the Association. Doctors: 9 advisory. Nurses: 1 assistant superintendent who is also supervisor of instruction, 1 maternity supervisor, 1 registrar, 3 supervisors, 18 general nurses, 2 obstetrical nurses. Clerical: 1 book-keeper, 3 clerical assistants. Volunteer workers: 63. The organization cooperates with three other agencies in supporting a generalized nursing experiment in one ward which consists of the following personnel: 1 supervisor, 4 staff nurses, 1 clerical assistant.

Type of work: Bedside nursing and supervisory visits in the home, to pre-natal patients, to women at time of confinement, to postpartum and postnatal patients, to all types of medical and surgical conditions, to chronic sufferers and tuberculous patients in need of bedside nursing. The communicable disease service includes all but cases of erysipelas, smallpox, diphtheria and scarlet fever.

Financial: The total budget for the year was \$67,370.48, 73 per cent of which was received from the Community Fund, 15 per cent from patients in payment for services, 12 per cent from miscellaneous sources. The cost per visit is \$1 and free care is given when necessary. Paid hourly nursing is offered at \$1.50 an hour.

General statement: The total visits made by the staff was 52,463; 7,589 patients were cared for. During the year 57 children attended a camp for children susceptible to tuberculosis.

St. Paul

DIVISION OF HYGIENE, DEPARTMENT OF EDUCATION

Organized 1909.

Aim: To safeguard the health of school children and to promote the efficiency of the school.

Board: No governing board. Work directed by Director of Hygiene, under superintendent of schools, and commissioner of education.

Territory: The Division serves the city of St. Paul with a population of 275,000.

Staff: Director of Hygiene. Doctors: 5. Oculist. Psychiatrist. Dentists: 4 (all part time). Nurses: 1 chief, 20 school, 3 high school, 3 dental. Nutrition worker.

Type of work: Examination and inspection of school children, including high school pupils, 4 health talks, sanitary surveys, home visits for follow-up work and investigations of absence. Securing data on retarded and behavior cases. Prophylactic and repair work in dental clinic. Nutrition classes and conducting milk stations. Classroom demonstration work with mother clubs.

Financial: Budget, \$50,000. Support is derived from the Department of Education of the City of St. Paul. Three dentists are paid by Women's Auxiliary to St. Paul District Dental Society.

ST. PAUL BABY WELFARE ASSOCIATION

Organized August, 1910.

Aim: To improve the health conditions of the children of St. Paul through the education of the mothers.

Board: The Association is governed by a board of 4 men and 5 women.

Territory: The Association serves an urban territory with a population of 275,000.

Staff: Director of the Association. Doctors: 1 supervisor, 13 part-time. Nurses: 1 supervisor, 2 general supervising, 10 staff. Social service worker: 1. Clerical assistants: 2.

Type of work: Home visiting, clinics and health centers are maintained for prenatal and postnatal patients as well as for infants and pre-school children.

Financial: The total budget for the year was \$22,000. The Association is supported by the community chest and contributions.

General statement: The number of infants given home care during the year was 3,791; the number of home visits paid to infants and pre-school children was 21,155; the infant mortality rate was 13 per 1,000 among children under care of the Association.

MISSISSIPPI

Jackson

BUREAU OF CHILD HYGIENE AND PUBLIC HEALTH NURSING, STATE BOARD OF HEALTH

Organized July 1, 1920.

Aim: Maternity, infant, and child hygiene.

Board: The governing board consists of the State Board of Health.

Territory: Entire state with a population of 1,789,182, which is largely rural.

Staff: Director of Bureau, supervisor of maternity and infant hygiene, supervisor of nutrition, supervisor of oral hygiene, and unit physicians, public health nurses, field agent of vital statistics, and clerical staff.

Type of work: Physical examination of infants, pre-school, and school children; follow-up work for the correction of defects found; organization of child welfare committees; lectures, health plays, and newspaper service; supervision of nutrition programs, supervision of midwives, demonstrations to mothers on the care and feeding of infants and children, supervisory care of women during prenatal, natal, and lying-in periods, oral hygiene work, and home hygiene classes.

Financial: The budget for the year was \$49,076.50, and is supported by federal, state and county appropriations.

General statement: A general physical examination has been given to more than 45,000 infants, pre-school, and school children. About 4,000 midwives have been investigated; permits issued when so indicated and intensive follow-up instructions given in group meetings and homes of the midwives. Instruction in nutrition has been given in the school to groups of mothers and children, and educational lectures have been given to civic clubs, and Parent-Teacher Associations. Oral hygiene work has been carried on by the supervisor working with the dentists, the field nurses, and school teachers.

MISSOURI

Kansas City

CHILDREN'S BUREAU

Organized May, 1919.

Aim: Health education, prevention of illness, reduction of infant mortality.

Governing board: Consists of five men and nine women.

Territory: Serves an urban and rural territory with a population of approximately 450,500.

Staff: Consists of an executive secretary, assistant secretary, dietitian, and two field workers.

Type of work: Education of volunteer workers; yearly census and examination of pre-school children; follow-up of cases needing attention; and assistance to parents in obtaining medical care for their children by private physician, clinics or hospitals; keeping a careful clinical record of each child for the information of parents, board of health, or school board; promoting classes in home hygiene, prenatal care, nutrition of infants and home nursing.

Financial: Budget for year amounted to \$12,000—received from the Charity Chest of the Chamber of Commerce.

General statement: The work is for children from birth to six years of age.

Statistics: Census, 18,002. Examined, 15,417. Children just entering school, 3,576.

In Well Children's Stations under Bureau direction: Examinations, 1,109. Consultations, 2,090. Nurses' visits, 4,978.

Pre-School Mothers' Circles organized, 22. Lessons, 128. Aggregate attendance, 1,244. Prenatal cases, 377.

MINUTE CIRCLE, FRIENDLY HOUSE

Organized April, 1918. Reorganized September, 1923.

Aim: To promote mental and physical health and facilitate good citizenship.

Board: The governing board consists of 21 women.

Territory: The territory covered by the visiting nurses has a population of 20,000. Other work of the neighborhood house is not confined strictly to this district.

Staff: The staff consists of an executive, a social service worker, a recreational director, 3 nurses (V.N.A.), 3 volunteer doctors and 10 volunteer workers.

Type of work: Neighborhood house program, including baby welfare, prenatal clinic with station, follow-up work, social service and case work in cooperation with other agencies, clubs, classes, and community gatherings.

Financial: The income for the year was derived from the Community Chest, interest from building fund, membership dues and donations.

THOMAS H. SWOPE SETTLEMENT

Organized 1903.

Aim: Social betterment.

Board: Men's board, 28 directors. Women's auxiliary, 36 members.

Territory: The territory served has an urban population of 15,000.

Staff: Superintendent. Doctors (volunteer), 43. Dentist. Nurses: 3 (1 social service). Druggist.

Type of work: Clinic, day nursery, clubs and classes, neighborhood work.

Financial: Funds are derived from the Community Chest and interest on small endowment, and from departmental receipts.

General statement: The work covers the following lines: Dispensary work following clinics: pediatric, orthopedic, medical, surgery, general nursing, ear-nose-throat, dermatology, neurology, gynecology, prenatal, X-ray, dental, eye, tuberculosis; day nursery, clubs and classes, music department, Sunday service, library, gymnasium, playground, case work.

VISITING NURSE ASSOCIATION

Organized 1891.

Aim: To give skilled nursing care to patients in their own homes and to teach health and prevention of disease.

Board: The governing board consists of 20 women.

Territory: The Association serves the entire city with a population of 400,000.

Staff: Superintendent. Doctors: 2 part-time (free service). Nurses: 4 supervising, 40 staff. Clerical assistants: 2.

Type of work: Home nursing care for maternal, prenatal, obstetrical, and postnatal cases, infants, pre-school children, and adults. Clinics for colored babies.

Financial: The Association is supported by funds from the Community Chest, membership dues, fees from pay patients, the Metropolitan Life Insurance Company and other organizations.

General statement: The Association conducts two child welfare clinics for colored babies. Clinic and follow-up work is done by six nurses for the Tuberculosis Society. The Association supplies nurses for all public health work done in the city with the exception of school and industrial nursing. This includes nurses for the health work conducted by St. Luke's Child Welfare Club, Jewish Educational Institute, Minute Circle Friendly House Association, Amberg Club, Children's Relief Society, Junior League, Children's Bureau, Swope Settlement, Whatsoever Circle, Community House, Institutional Church, Mexican Christian Mission, and Italian Presbyterian Mission. A total of 106,440 visits were made last year among the sick and poor; 55,024 visits were made in connection with child welfare work.

St. Louis

MISSOURI STATE NURSES' ASSOCIATION

Organized 1904.

Aim: To elevate the standard of nursing education.

Board: There are 11 members on the governing board.

Financial: Funds are derived from membership dues.

MUNICIPAL VISITING NURSES

Organized September, 1915.

Aim: To provide instructive supervision through clinics and home visits for prenatal, infant, pre-school and tuberculosis cases.

Board: The governing board consists of 3 men and 4 women.

Territory: The organization serves the city of St. Louis, with a population of 812,698.

Staff: Superintendent. Supervisors: 5. Staff nurses: 28. Clerical assistants: 5. Doctors: 2 full-time, 16 part-time. Volunteers: 60.

Financial: Budget, \$74,070. Supported from the municipal revenue.

General statement: In 1923 there were held 201 prenatal clinics, 1,121 child welfare clinics and 904 tuberculosis clinics. Visits made to homes, 4,698.

ST. LOUIS CHILDREN'S AID SOCIETY

Organized 1909. Incorporated 1911.

Aim: To give individual care in free and boarding foster homes to partially dependent normal children and to delicate babies and older children who are dependent and present health and conduct problems; to find employment for unmarried mothers enabling them to keep their babies; and to supply wage homes for older boys and girls.

Board: The governing board consists of a board of directors and an executive committee.

Territory: Cares for St. Louis children.

Staff: General secretary; office secretary; director of investigation and two workers; director of supervision and three workers; trained nurse; home-finding department with two workers; two stenographers; occasional volunteers from the Missouri School of Social Economy.

Type of work: Careful supervision in foster homes; preventive health work and infant care.

Financial: Since January, 1923, support has been supplied by the community fund.

General statement: The medical work (treatment of visual, dental, mental, orthopedic, and venereal disease) is accomplished through the Washington University Dispensary, and the dental work through the St. Louis University Dental Clinic. Hospital care is given by St. Louis Children's Hospital and occasionally by the Municipal Hospitals.

Number of children handled, November, 1922, to January, 1924, 1,431.

Number of visits made, November, 1922, to January, 1924, 11,696.

ST. LOUIS MATERNITY HOSPITAL

Organized 1908.

Aim: To maintain a non-sectarian institution for the care of maternity cases.

Board: Executive board of 27 women; the entire board has 43 members.

Territory: The hospital serves the entire city.

Staff: Hospital superintendent and accountant. Resident physician and a staff of 30 consultants. Nurses: a training school superintendent, and 3 graduate assistants; 1 night superintendent and 14 students.

Type of work: Maternity care for expectant mothers; a prenatal clinic is held five days of the week.

Financial: The Hospital is supported by endowment, membership dues, fees from private patients and the Community Fund.

ST. LOUIS PEDIATRIC SOCIETY

Organized November 22, 1885.

Aim: To promote the art and science of pediatrics, to stimulate the interest of the profession in this special branch of medicine, to spread the knowledge of public and private hygiene in so far as it affects the welfare of children.

Territory: The Society serves an urban territory with a population of 1,000,000.

Type of work: The Society, as an organization, does no welfare work but its individual members work through the other organizations in the community.

VISITING NURSE ASSOCIATION OF ST. LOUIS

Organized 1909. Incorporated 1911.

Aim: To promote public health by providing skilled nursing care to the sick in their homes and by teaching the principles of health and hygiene.

Board: The governing board consists of 30 women.

Territory: The Association serves an urban population of 772,000, and a rural population of 100,000.

Staff: Nurses: 46 graduate, 3 student. There are 11 colored nurses on the staff.

Type of work: Home visiting, maternal, prenatal, postnatal, and infancy. Industrial, tuberculosis and venereal disease patients are served. Preventive work emphasized.

Financial: Budget for 1924, \$92,963. Support is derived from the Community Fund, fees, and Metropolitan Life Insurance Company.

General statement: The Visiting Nurse Association offers the usual bedside care to whoever may need it in St. Louis, and St. Louis County. A large part of the work is prenatal and postnatal maternity service. Transportation in the city is only fair, and rural work must be covered by machines.

NEBRASKA

Lincoln

DIVISION OF CHILD HYGIENE, DEPARTMENT OF HEALTH AND WELFARE

Organized September 15, 1921.

Aim: Preventive and educational work.

Board: The division is under the control of the State Department of Health and Welfare.

Territory: Both urban and rural territory is served.

General statement: The division has been devoted entirely to the maternal and infant welfare under the provision of the Sheppard-Towner Act.

Omaha

THE VISITING NURSE ASSOCIATION OF OMAHA

Organized 1896.

Aim: To give skilled nursing care to the sick in their homes; to teach personal hygiene, cleanliness, and the prevention of disease.

Board: The Association is governed by a Board of Directors consisting of 30 women.

Territory: The Association serves an urban territory with a population of 200,000.

Staff: Superintendent, 2 supervisors, 2 assistant supervisors, 1 registrar, 1 nutritionist, 24 field nurses, 6 student nurses, 2 clerical assistants, 1 statistician, 4 doctors, part-time (volunteer), 12 Junior League part-time volunteer workers, 2 clerical assistants, part-time (volunteer), Medical Advisory Board.

Type of work: Bedside nursing, prenatal, delivery, postnatal nursing, infant welfare, tuberculosis, industrial and orthopedic. Generalized in one section of the city.

Financial: The total budget amounted to \$45,199. The organization is supported by the Community Chest, membership dues, receipts from patients and Metropolitan Life Insurance. The salary of 3 nurses is paid as follows: 1 by the city, 1 by Nebraska Tuberculosis Association, and 1 by the American Smelting & Refining Company.

General statement: Prenatal: The Association cooperates with the University of Nebraska and Creighton Medical clinics. Prenatal instruction given to 1,335 expectant mothers. Average number of months under care, three and one-half. A complete maternity program at the time of confinement; 5,185 visits were made in the home; 250 deliveries. Average time spent on deliveries, 3 hours, 50 minutes. Maternal death rate, 2; 5 stillborn; 2 babies died at birth.

Infant welfare: Education of mothers in care of infants by conferences with physician and home visiting by the nurse. Breast feeding is encouraged; formulae demonstrated; 15,000 home visits were made on 1,490 babies; 7 weekly conferences held; attendance, 7,692. Little Mothers' Clubs teach little girls, in groups of ten, health and care of the baby.

Tuberculosis service: Functions through the clinics at the University and Creighton Medical Schools. Besides the active cases, 1,500 contracts are under supervision.

Orthopedic: Functions through the above named clinics and in cooperation with the Hattie B. Munroe Convalescing Home for Cripples.

Nutrition: 2 nutrition clinics are conducted weekly for pre-school age children.

Posture: Posture class given at Social Settlement.

Social work and health teaching is carried on in each division of work.

NEVADA

Reno

CHILD WELFARE DIVISION OF STATE BOARD OF HEALTH

Organized July, 1922.

Aim: Prenatal, infant and pre-school betterment.

Board: The governing board consists of 5 members.

Territory: The division serves an urban and rural population of 70,000.

Staff: Executive secretary. Public health nurses: 6.

Type of work: Home visiting, pre-school classes, health center.

Financial: Budget, \$16,044. Support is derived from Sheppard-Towner and state funds.

NEW HAMPSHIRE

Manchester

MANCHESTER HEALTH DEPARTMENT

Organized 1885.

Aim: To administer health laws, to institute and administer measures for the preservation of public life, and to conduct the Isolation Hospital.

Board: The governing board is composed of 3 men.

Territory: An urban territory with an estimated population of 85,000 is served.

Staff: Health Officer who is also superintendent of the Isolation Hospital; 2 clerks; 2 sanitary inspectors; 1 milk inspector; 1 market inspector; 1 slaughter inspector; 3 school physicians, part-time; 6 school nurses; 5 infant welfare nurses; 1 tuberculosis nurse; 1 venereal disease nurse; 2 school dentists, part-time; 2 dentists' assistants. At the Isolation Hospital: superintendent; 1 resident physician, who is also the bacteriologist; superintendent of nurses; 3 nurses (other nurses engaged when number of patients so requires); and other necessary employees. All are full-time unless otherwise indicated.

Type of work: General health administration such as would be required in any city: sanitary, tenement, barber shop, ice cream factory, candy factory, store, food, milk, slaughter house, boarding house, meats, meat products inspections; physical examinations of school children; dental examinations and treatments of school children; control of communicable diseases; Schick test and toxin-antitoxin treatments; both chemical and bacteriological examinations of milk; treatment of communicable diseases; tuberculosis clinic for advice and treatment; venereal disease clinic for advice and treatment; 3 infant welfare clinics for prenatal and infant care and home visiting for children up to two years of age.

Financial: The budget for the year 1924 was \$75,000.

General statement for 1923: Infant Welfare Department, 3,262 babies under supervision; 13,278 home visits made; 283 clinics held; 3,553 visits to stations. Isolation Hospital: 198 patients treated. Venereal disease clinic: 484 patients treated; 5,897 treatments given. Tuberculosis clinic: 46 clinics held; 579 patients; 1,526 home visits. School Medical Inspection Service: 5,902 children examined. School Dental Service: 6,178 children examined; 5,662 treatments given. The new milk ordinance became operative November 1, 1924. This ordinance provides that all milk, cream, skimmed milk, or buttermilk sold in Manchester shall be either pasteurized or drawn from tuberculin-tested non-reacting cattle, the test to be official. Pasteurized milk must have not more than 25,000 bacteria per c.c. and tuberculin tested milk not more than 50,000 bacteria per c.c. Milk and cream used in the manufacture of ice cream must conform to these standards.

NEW JERSEY

Atlantic City

ATLANTIC CITY DAY NURSERY

Organized 1906.

Aim: To receive and care for during the day the young children of poor, industrious women whose employment calls them from their homes and who would otherwise be obliged to leave their children entirely without protection.

Board: The governing board consists of 5 men and 23 women.

Territory: Serves an urban territory.

Staff: The staff consists of a director, an assistant and medical director (volunteer service).

Financial: The total budget for the year amounted to \$3,525.03. The organization is supported by voluntary contributions, membership dues, appropriations from city and contributions from members. A fee of from five to ten cents a day per child is charged.

General statement: The Day Nursery is conducted under the auspices of the Atlantic City Branch of the Mothers' Congress, incorporated to maintain a day nursery for white and colored children.

CHILD FEDERATION OF ATLANTIC CITY

Organized May 5, 1916.

Aim: To actively advance the best interests of the babies and children of Atlantic City; to safeguard their moral, mental and physical health.

Board: The governing board is composed of 3 men and 17 women.

Territory: The Federation serves an urban territory with a population of approximately 50,682.

Staff: Chief nurse doing field work as child hygiene teacher. 1 nurse, full-time 4 months, half-time throughout year as necessary (prospects for full-time in near future). 1 supervising physician, 2 volunteer physicians in clinic, with prospect of 1 and perhaps 2 more during the present year. Volunteer workers, in clinic, 4 to 6 as needed.

Type of work: Home visiting and clinics for prenatal and postnatal patients as well as for babies and pre-school children are conducted. Preventive and educational work are features of the service rendered.

Financial: The total budget for the year is \$3,500. The Federation is supported by membership dues, appropriations, contributions, also by card parties and lawn fêtes.

General statement: Supervised by New Jersey State Child Hygiene Division, and carrying full program of that department. During the year 3,152 visits were made as follows: expectant mothers, 584; babies under 1 year, 1,961; second year pre-school, 607. Consultation station: total attendance, 2,336; expectant mothers, 33; babies under 1 year, 1,672; pre-school, 631.

Jersey City

HUDSON COUNTY TUBERCULOSIS LEAGUE

Organized 1918.

Aim: Prevention of tuberculosis.

Board: There are 28 members on the governing board.

Territory: The territory served has a population of about 600,000, largely urban.

Staff: There are 5 members on the staff.

Type of work: Preventive and educational.

Financial: The budget for the year is \$24,000. Funds are derived from the sale of Christmas Seals.

General statement: The family work of prevention of tuberculosis is done in cooperation with the State Board of Children's Guardians. The League investigator makes out the budget for the family. The League has supplied a nurse to do nutri-

tion work and conduct dental clinics in sections of the county where there is no school nurse. Health talks have been given to clubs and schools throughout the year. Poster contests have constituted an interesting and constructive part of the program. It is planned to go into the industries to do periodic health examinations during the coming year.

Newark

THE BABIES' HOSPITAL

Organized May, 1896.

Aim: Care and feeding of children.

Board: The Hospital is governed by a board of 16 men directors and a board of 60 women managers.

Territory: The entire state receives service.

Staff: Medical staff: medical director, 8 attending physicians, 9 associate physicians, 6 attending surgeons, 3 associate surgeons. Nursing staff of hospital: superintendent, 2 supervising nurses, 12 student nurses. Social service department: 2 visiting nurses, 1 milk dispensary nurse, 1 clerical worker.

Type of work: Hospital and clinic care for sick infants, consultation and home visiting for preventive and educational work.

Financial: The total budget amounted to \$27,524.12. The Hospital is supported by appropriation from the city, subscriptions and contribution from governing boards, contributions and board receipts from pay patients.

General statement: During the year 496 patients were admitted to the hospital, 10,402 hospital days' treatment, 1,250 patients at clinics, 3,287 cases at consultations, 4,426 home visits, 10,449 feedings dispensed.

Orange

DIET KITCHEN OF THE ORANGES

Organized 1904.

Aim: Supervision and instruction in the care and feeding of babies and pre-school children, and the dispensing of pure milk to babies, undernourished children, the sick and the tuberculous.

Board: The governing board consists of 14 women.

Territory: An urban territory is covered.

Staff: Nurses: 3 who act as supervisor and field workers; doctors: 3 full-time, 2 part-time; social worker: 1; social worker's assistant: 1.

Type of work: Home visiting, clinics, and health centers are maintained particularly for infants and children of pre-school age.

Financial: The budget for the year was \$35,874. The organization is supported by the Welfare Federation of the Oranges, membership dues and special contributions. It is about 81 per cent self-supporting.

General statement: During the year the nurses made 10,365 visits. A very important branch of the work is the milk distribution: 220,000 quarts of milk were dispensed in 1922. Grade "A" pasteurized bottled milk is delivered to the homes of the babies or may be obtained at one of the weighing stations. The patients pay 80 per cent of the cost. We have 5 clinics each week at which the doctors and nurses are present. The doctors are paid for their services.

Plainfield

VISITING NURSE ASSOCIATION OF PLAINFIELD AND NORTH PLAINFIELD

Organized July 1, 1911.

Aim: To provide trained nurses for all home nursing (other than full-time private nursing) in and about Plainfield, school nursing, and instructive health work.

Board: The governing board consists of 4 men and 13 women. Vacancies, 2.

Territory: The Association serves an urban and rural territory with a combined population of 50,000.

Staff: Executive secretary; doctors: 7 part-time volunteer (at baby stations); nurses: 9 staff; social workers: 5 part-time, volunteer (at baby stations); 4 paid, part-time (at nutrition classes); nutritionists: 4 of the nurses, part-time.

Type of work: Home nursing care for all ages, including maternal, prenatal, obstetrical, visual, mental, cardiac, orthopedic, industrial, tuberculosis and venereal disease cases; baby health stations, school nursing and nutrition classes.

Financial: The budget for the year was \$21,050 (estimated). The Association is supported by community chest, appropriations, and contributions.

NEW YORK

Albany

NEW YORK STATE DEPARTMENT OF HEALTH, DIVISION OF MATERNITY, INFANCY AND CHILD HYGIENE

Organized 1914.

Aim: To safeguard motherhood and protect the health of infants and children.

Territory: The Division serves the entire state with an urban population of 2,604,614 and a rural population of 2,158,159.

Staff: Doctors: 6, 18 part-time. Nurses: supervisor, 30 special. Nutritionists: 1. Clerical assistants: 10.

Type of work: Consultation service for organizing child hygiene work; consultant nursing service, to assist and advise local nurses; prenatal consultation service for instruction and examination; surveys and studies of local health conditions pertaining to maternity, infancy and child health and investigation of puerperal deaths; organization service for stimulating a community to assist in child hygiene work; plans for women's organizations in extending the health work of their committees; extension courses for nurses, comprising lectures and demonstrations in maternity hygiene; nutrition service for instruction of nurses and mothers and for nutrition extension in children's institutions; publicity, including the preparation and distribution of literature, films, talks by radio, addresses, and press notices; cooperation with other organizations in breast feeding demonstrations; licensing and supervision of midwives, boarding homes and maternity hospitals, also orthopedic consultations for aftercare of poliomyelitis; rural traveling child health consultations; supervision and advice to mother and child hygiene stations; promotion of sterile obstetric package; furnishing standardized umbilical dressing to midwives; organization of teaching center; demonstrations at county fairs; participation with local communities in financial support of maternity and infancy nurses and doctors.

Financial: The total budget for the year amounted to \$287,000 (part of which is Sheppard-Towner appropriation), and is supported by a state appropriation.

General statement: The policy of the State Department of Health through the

Division of Infancy and Maternity Hygiene is to stimulate local communities to extend or to organize maternity and child hygiene activities through their own local organization and to give such assistance as is possible to these localities in working for mothers and children; regional consultants who are recognized leaders in obstetrics and pediatrics in the state assist in securing the cooperation of the medical profession.

STATE BOARD OF CHARITIES

Organized in 1876; became Constitutional body January 1, 1895.

Aim: The principal duties of the Board are to visit, inspect, and maintain a general supervision of all institutions, societies or associations which are of a charitable, eleemosynary, or correctional character, whether state or municipal, incorporated or unincorporated, made subject to its supervision by the constitution and the statutes of the state. Other duties are to establish rules for the reception and retention at public expense of inmates of private institutions, to approve or disapprove the organization and incorporation of all the institutions which are or may become subject to the supervision of the Board; to license dispensaries and establish rules for their conduct; supervise the placing out and boarding out of dependent children; supervise the work of boards of child welfare; secure the just, humane, and economic administration of all institutions subject to its supervision; advise the officers of such institutions in the performance of their official duties; aid in securing the erection of suitable buildings for the accommodation of inmates in such institutions; aid in securing the best sanitary condition of the buildings and grounds of all such institutions, and advise measures for the protection and preservation of the health of the inmates; aid in securing the establishment and maintenance of such industrial, educational and moral training in institutions having the care of children as is best suited for inmates; investigate the condition of the poor seeking public aid and advise measures for their relief; administer the laws providing for the care, support and removal of state, non-resident, and alien poor, and the support of Indian poor persons; collect statistical information in respect to the property, receipts and expenditures of all institutions, societies and associations subject to its supervision, and the number and condition of the inmates thereof, as also of the poor seeking temporary public relief.

Board: The governing board consists of 8 men and 4 women.

Territory: The entire state is served, with a population of 11,000,000.

Financial: The total budget for the year amounted to \$197,254 and is furnished by the state.

Brooklyn

MATERNITY CENTER ASSOCIATION OF THE BOROUGH OF BROOKLYN

Organized August, 1918.

Aim: The Association aims to teach the public the vital importance of adequate maternity care, and to secure in cooperation with all existing agencies such care for the women of Brooklyn.

Board: The Association is under the joint control of the medical advisory board, consisting of 4 men; and the board of directors, consisting of 48 women.

Territory: The Association serves an urban territory.

Staff: Doctors: 2 part-time. Nurses: Director, 3 staff. Clerical assistant. Volunteer workers, 6.

Type of work: Home visiting and clinics are conducted for prenatal and post-

natal patients. Classes are held for prenatal patients and preventive and educational work is carried on.

A Mothercraft Club for women who can pay club dues was opened October 1, 1924.

Financial: The budget for the year was \$12,000, plus a \$10,000 budget for the Mothercraft Club. Of the fund, \$5,000 was given by the Laura Spelman Rockefeller Memorial.

VISITING NURSE ASSOCIATION OF BROOKLYN

Organized 1888.

Aim: To give skilled care to the sick in their homes; to teach personal hygiene and the hygiene of pregnancy, sanitation and the prevention of disease. The Association cooperates actively with the Health Department, physicians, hospitals, dispensaries, and other social agencies, and is affiliated with the Children's Welfare Federation.

Board: There are 30 members on the governing board.

Territory: The territory covered is urban with an area of 81 square miles.

Staff: Graduate nurses: 90.

Financial: Funds are derived from service money, contributions, and income from endowment funds. The budget for the current year is \$153,075.76.

General statement: The Visiting Nurse Association is organized to provide general nursing care in the homes on a visit basis, to teach personal hygiene, the hygiene of pregnancy and the prevention of disease, and as far as possible to solve social and economic problems arising in the homes, referring the problems to cooperating agencies wherever necessary. Except for a special staff of 12 orthopedic nurses constantly treating infantile paralysis and patients with other orthopedic conditions, the service is generalized. Prenatal and postnatal care are given and patients are visited at intervals for six weeks after delivery.

Buffalo

DISTRICT NURSING ASSOCIATION

Organized 1887.

Aim: The objects of the Association are: to provide graduate nurses registered in the state of New York for patients not requiring continuous nursing care, and to provide such other service as may from time to time be necessary to give efficient care to the sick; to teach home nursing, hygienic living and proper care of children; to stimulate community responsibility for the health of the community, and to cooperate with other social agencies to this end.

Board: There are 30 members on the governing board.

Territory: The territory served has a population of about 600,000.

Staff: Registered nurses: 45. Clerks: 3. Aides, not trained: 5. Stenographer.

Type of work: General public health nursing. Home visiting, clinics, classes.

Financial: Budget for current year, \$100,750. Funds are derived from patients' fees and Joint Charities Fund.

Canaan**BERKSHIRE INDUSTRIAL FARM**

Organized 1886.

Aim: To study, train and re-educate the problem boy.

Board: The governing board consists of 10 men.

Staff: Superintendent and educational director; assistant superintendent and athletic director; consulting psychiatrist and director of research; physician; resident psychologist; psychiatric social worker; secretary; field agent; dental surgeon; 2 volunteer oral hygienists; nurse; clerical assistants; matrons; vocational and academic teachers.

Type of work: Study, care, and training of boys intrusted to the institution. Academic, trade and agricultural courses are given. The health work and mental hygiene are under the direction of a physician and psychiatrist, resident psychologist and a psychiatric social worker. Mental defects corrected and regular prophylaxis treatments given. Orthopedic conditions treated and corrected. Special attention is given to nutrition and the boys are weighed every month.

Financial: The total budget for the year amounted to \$95,000 and is supported by educational grants and contributions. A charge of \$6 per week per boy is minimum cost.

Ithaca**HYGIENE DEPARTMENT, CORNELL UNIVERSITY**

Organized 1919.

Aim: To provide health education, health service and sanitary service to the student body of Cornell University.

Board: The governing board includes 50 members of the Board of Trustees of Cornell University.

Territory: The territory covered is urban with a population of 5,000.

Staff: Physicians: 2 women, 7 men. Laboratory technician. Clerks: 2.

Type of work: Clinics, classes, hospital.

Financial: The budget for the current year is \$33,730. Funds are derived from the University.

General statement: The department is organized primarily to furnish health and sex education, and secondarily to provide health service to the students and sanitary service to the University community.

Jamestown**JAMESTOWN VISITING NURSE ASSOCIATION**

Organized January 6, 1909.

Aim: The prevention of disease, health education, and bedside nursing of the sick at home.

Board: The governing board consists of 6 men and 7 women.

Territory: An urban territory with a population of approximately 38,917 is served.

Staff: Doctors: 1 supervisor, 6 volunteers. Nurses: Director and one supervising nurse, 4 staff. Clerical assistant: 1.

Type of work: Bedside nursing to all the sick; clinics for prenatal patients,

infants and children; health center for infants, Little Mothers' League classes, instructive home visiting, infant and prenatal.

Financial: The budget for the year is \$7,390.96. The Association is supported by the Community Chest, appropriations and donations. Fees are regulated for each patient.

General statement: The Association made a survey of all crippled children in the city for the Rotary Club and has given special exercises to these children, supervised by the State Orthopedic Department and state nurses.

Baby Week is observed every year, that is, a week is devoted to the examination of infants up to 2 years of age. These babies report once a month for weighing and advice.

New York

AMERICAN NURSES' ASSOCIATION

Organized 1897.

Aim: To promote the professional and educational advancement of nurses in every proper way; to establish and maintain a code of ethics among nurses; to elevate the standard of nursing education; to distribute relief to such nurses as may become ill, disabled, or destitute; to disseminate information on the subject of nursing by publication of official periodicals or otherwise; to bring into communication with each other the various nurses and associations and federations of nurses throughout the United States of America; and to succeed to all rights and property held by the American Nurses' Association as a corporation duly incorporated under and by virtue of the State of New York.

Board: There are 11 members on the board of directors.

Territory: The territory covered is 49 states and 2 territories.

Staff: Director, field secretary, and 2 clerical assistants.

ARGONNE ASSOCIATION OF AMERICA, INC.

Organized July 13, 1920.

Aim: To provide for the child who has no parents a home and a family life; to secure him his birthright of health; to educate him and train him to earn his livelihood; to develop his character that he may become an upright and a useful citizen; and to do these things so well and so economically that others will follow this example.

Board: There are 15 members on the governing board.

Type of work: Home visiting, clinics, and other methods.

Financial: The budget for the current year is 600,000 francs. A little less than half is raised in France through various government organizations, and the balance in America by private subscription.

THE BABIES' HOSPITAL OF THE CITY OF NEW YORK

Organized 1887.

Aim: To provide medical and surgical aid and nursing for sick babies.

Board: The governing board consists of 12 men and 3 women.

Territory: The Hospital serves an urban territory.

Staff: Superintendent. Doctors: Resident physician and 4 internes. Nurses: Assistant superintendent, 1 supervising, 4 staff, 1 infants'. Social workers: Director, 2 full-time. Nutritionists: 1 full-time, 3 students. Clerical assistants: 4.

Type of work: Hospital care and clinics for infants, home visiting to follow-up hospital care and to instruct mothers; training school for infants' nurses, and post-graduate courses for graduate nurses; lectures to fourth year students of College of Physicians and Surgeons and research work.

Financial: The total budget for the year amounted to \$89,582, and is supported by appropriations from the city, contributions and endowment fund. The hospital fee is from \$3 to \$7 per week for board; dispensary, 25 to 50 cents (50 cents first visit, 25 cents succeeding visits).

General statement: During the year 4,387 patients visited the clinic, 3,227 home visits were paid; 2,104 patients were given home care and 1,808 patients were given hospital care.

BUREAU OF EDUCATIONAL EXPERIMENTS

Organized 1915.

Aim: Scientific study of young children.

Board: The Working Council has 12 members.

Territory: New York City.

Staff: Head of Nursery School. Physician. Psychologists: 2. Social worker.

Type of work: Nursery school and psychological and physical research.

Financial: The budget for the current year is \$32,716.

General statement: The Bureau's work is at present only with the children in its own Nursery School, and with those in the city and country school with which it cooperates.

CHILDREN'S WELFARE FEDERATION

Organized June, 1912.

Aim: To reduce morbidity and mortality of infants and children; to promote their physical, mental and social welfare by acting as a clearing house for information regarding welfare work for children and fostering practical cooperation among all the forces in the field in order that duplication of effort may be avoided and each society in the Federation may become more effective.

Board: The governing board consists of 20 men and 10 women.

Territory: The Federation serves the city with a population of 6,000,000.

Staff: Executive secretary; clearing house for maternity cases and bureau for collection and distribution of mother's milk: one trained nurse as supervisor, three matrons and one substitute matron, three clerks; clearing house for children's cases: one trained social worker in charge; bureau of local health conferences: one trained social worker in charge; information service and special surveys: one trained investigator in charge; department of publicity: extension secretary and two clerks; one office manager; one general clerk. Partial stenographic service furnished by the Department of Health.

Financial: The total budget for the year amounted to \$38,162.50 and is supported by membership dues, grants from foundations and individual contributions. Light, heat, rent and partial telephone service supplied by the Department of Health.

EAST HARLEM NURSING AND HEALTH DEMONSTRATION

Organized January 1, 1923.

Object: A unification of effort, support and administration for a complete nursing and nutrition program in a limited area.

Governing board: Consists of 16 members—9 women and 7 men.

Territory: The Demonstration serves 20 city blocks, with a population of approximately 40,000, of which 90 per cent are Italians.

Staff: Director and associate director, a supervisor of the nursing service, 4 assistant supervisors, 13 field nurses, a supervisor and assistant supervisor of nutrition service with 2 field nutritionists, a statistician, office secretary, stenographer, typist and telephone operator, one half-time and 3 full-time clerical assistants, 4 part-time physicians and a part-time posture worker.

Type of work: A generalized nursing and nutrition program, including bedside nursing, prenatal and postnatal, infant welfare, and work with the pre-school child. Prophylactic clinics are held for expectant mothers, infants and pre-school children.

Financial: The Demonstration is supported by the four health organizations who are interested in the unification, viz., \$10,000 each from the A. I. C. P., American Red Cross, and Henry Street; \$2,500 from the Maternity Center Association. This amount is subsidized by an equal amount from the Laura Spelman Rockefeller Memorial, making a total budget of \$32,500.

General statement: All of the services of the Demonstration are free, with the exception of the bedside nursing. The child welfare program includes the child from conception to school age. Work with the child is done in the home and at the center. The ratio of service is about 4 home visits to 1 visit to the center. Physicians in the maternity, infant and pre-school services are specialists and are employed on an hourly basis.

FEDERATION FOR CHILD STUDY
SUMMER PLAY SCHOOLS

Aim: To develop a method whereby the various agencies of a community may be utilized to

1. Provide a well rounded all-day program for children who are left in the city during the summer vacation.
2. Make a lasting contact with the home and the mother.

Type of work: The program is carried out as follows:

1. (a) Play—Outings, swimming, games, dancing, dramatics, music, story, and library period, shop work, cobbling, printing, sewing, cooking, arts and crafts, nature study.
(b) Health—Daily scoring in cleanliness, effort, courtesy, and improvement; showers, lunch, afternoon nap; scheduled classes for hygiene and health instruction.
(c) Canteen—In charge of expert dietitians. Provides and teaches the essentials of an adequate hot luncheon. Makes the school menus a basis for home instruction to mothers in proper diet and food preparation.
2. (a) Articles made in the Play Schools carry messages of good taste and cleanliness into the home.

- (b) Home visitor goes into the home for personal talks and gets consent for remedial work, or to follow up absentees.
- (c) Mothers' Days observed in each school at which the mothers are given simple talks on nutrition and other phases of child life.
- (d) Mothers' Clubs on Mothers' Days and carried throughout the winter with speakers from the Extension Bureau of the Federation for Child Study.

HENRY STREET VISITING NURSE SERVICE

Organized 1893.

Aim: To give trained nursing service to the sick in their homes; instruction in personal hygiene, sanitation and the prevention of disease; and to aid in adjustment of related social and economic problems.

Board: The governing board consists of 9 men and 4 women.

Territory: An urban territory with a population of 5,621,151 is served.

Staff: Nurses: 1 administrator, 1 general director, 1 associate director, 1 educational director, 3 field directors, 29 supervising, 203 staff and student. Statistician: 1. Clerical assistants: 26.

Type of work: Home visiting, clinics, classes, and health centers are maintained, particularly, for mothers and children. Educational and preventive work are given special attention. All ages are served.

Financial: The total budget was \$450,000. The organization is supported by contributions, returns from nursing service and income from investments. Fees are adjusted to family circumstances.

General statement: During the year 1923, 387,870 visits were made by nurses; 50,300 patients were given care.

HOSPITAL SOCIAL SERVICE ASSOCIATION OF NEW YORK CITY, INC.

Organized 1912.

Aim: To stimulate the growth of social work in hospitals and dispensaries, and to standardize such work; to organize experimental social service work and to collect and correlate information in regard thereto; to hold public meetings and to disseminate information through publications and otherwise in regard to hospital social service.

Board: The governing board consists of 11 men and 3 women.

Financial statement: The total budget for the year was \$10,000 and is supported by voluntary contributions, membership dues and magazine subscriptions.

JEWISH BOARD OF GUARDIANS

Organized 1902.

Aim: A coordinated effort for the prevention and correctional treatment of delinquency among Jews—juvenile, adult, male and female.

Board: The governing Board consists of a Central Council of 7 men and 3 women.

Territory: The Board serves the greater City of New York.

Staff: Executive director, assistant executive director. Case supervisors: 2. Social workers: 28 (full-time). Clerical assistants: 14. Doctors: 3 volunteers (part-time). Psychologist. Psychiatrist.

Type of work: The work of the Board is carried on by three committees:

the committee on Hawthorne and Cedar Knolls Schools for the education and training of boys and girls; committee on outside activities through the preventive, after-care, parole and unmarried mothers departments and the Big Brother and Big Sister groups; the committee on Lakeview home which provides shelter for the unmarried mother and her child and trains the mothers to earn a livelihood.

JUDSON HEALTH CENTER

Organized January 12, 1921.

Aim: The Judson Health Center is an independently incorporated organization working without regard to creed or color, devoting itself to health education, and health problems, both preventive and curative.

Board: The governing board consists of 30 members, men and women.

Territory: The territory covered is urban, with a population of approximately 45,000.

Staff: Volunteer staff: 1 general director, 15 doctors, 4 consulting doctors, 4 aids. Paid staff: 1 associate general director, 1 supervisor of nursing, 10 registered nurses, 1 supervisor of nutrition, 4 dietitians, 1 supervisor of social investigations, 3 Italian interpreters and visitors, 1 supervisor of dentistry, 6 dentists (part-time), 1 oral hygienist, 1 physiotherapist (supported by the New York Rotary Club), 1 registrar, 1 assistant registrar, 2 pages, 6 clerical workers, 1 nursery-school teacher, 1 Italian interpreter and teacher, 4 nursery assistants.

Type of work: Maintains diagnostic and nutrition clinics for infants and children; general medical clinics for men, women and children; prenatal and gynecological clinics; orthopedic, skin, and eye, ear, nose and throat clinics; dental and oral hygiene clinics; conducts cooking and nutrition classes for mothers and children; sends registered nurses and graduate dietitians or Italian visitors into the homes for instruction and follow-up care; operates two health nurseries with a roof playground, for a selected number of malnourished and rachitic infants and pre-school children, giving them special care with sunshine and correct diet. Their mothers are given group instruction in child care.

Financial: The total budget for the year was \$96,996. The Center is supported by membership dues, contributions, and fees.

General statement: Several factors influence the work. The population is almost entirely Italian. There are only two other health agencies in the district, one a baby feeding station and the other a tuberculosis clinic. The baby death rate in the 1920 census was 95, as compared with 85 for city at large. Treatment paves the way for education in preventive measures. The district is badly congested and the tenements are in bad condition.

MATERNITY CENTER ASSOCIATION

Organized April, 1918.

Aim: (1) To teach the public the vital importance of adequate maternity care. (2) To secure, in cooperation with all existing agencies, such care for all expectant mothers.

Board: The Board of Directors consists of 40 women and 6 men.

Territory: That section of Manhattan lying between 14th and 54th Streets—from Fourth Avenue to the East River, having a population of about 160,000.

Staff: General director; field director and associate field director and 1 clinic supervisor; 2 part-time clinic physicians; 22 staff nurses; 5 clerical workers. (Number of volunteer workers varies.) Finance and publicity secretary.

Type of work: Maternity Service, including medical and nursing supervision and care during pregnancy, nursing assistance to doctor or midwife at the time of delivery, nursing care during the postpartum period and a postpartum medical examination. Also an ambulatory clinic service, conducted in district centers of the A. I. C. P., the Department of Health, the Visiting Nurse Service of Henry Street and the N. Y. Diet Kitchen Association to provide medical service for the patients to whom they give nursing care.

The supervision during pregnancy consists of visits to each patient in her home; the patient's visits to the nurse at the Center; the patient's visits to the doctor at the Center; the patient's visits to the Center for group instruction. Visits to the patient in her home are made because the patient must be cared for and advised in relation to her family and environment. The patient's visits to the nurse help to make the patient realize her responsibility for the care of herself and baby, and reduce the cost of that care by reducing the time spent in travel by the nurse. The patient's visits to the doctor at the Center make possible medical supervision for those patients who will be delivered by midwives and those who delay in engaging their own doctor or registering at a hospital. Group instruction provides the contact with other mothers and stimulates discussion, which makes teaching more effective and less costly.

Financial: The total budget for the year was \$85,711.22. The Association is supported by voluntary contributions, receipts from a Thrift Shop, several musicales or other entertainments, a sale in cooperation with a department store and fees from patients.

MULBERRY COMMUNITY HOUSE

Organized June 2, 1920.

Aim: To democratically direct the social, civic and recreational activities of the people, mostly Italian, living in this densely populated district.

Board: The staff consists of 7 full-time workers, and 6 part-time workers. The average number of volunteers a month is 25.

Type of work: The social and recreational group work includes social clubs, gymnasium, entertainments, classes for children and adults, country outings, dramas for adults and children, civic education which includes English classes for men and women, citizenship training classes, group work along civic and health lines with mothers, men, working girls and boys and a host of unorganized ministries which spring up spontaneously to supply a quick but transient need.

NATIONAL CHILD LABOR COMMITTEE

Organized 1904.

Aim: To promote the interests of children; to investigate and report facts concerning child labor; to raise the standards of public opinion and parental responsibility with respect to the employment of children; to assist in protecting children by suitable legislation against premature or otherwise injurious employment, and thus aid in securing for them an opportunity for elementary education and physical development sufficient for demands of citizenship and requirements of industrial efficiency; to aid in enforcement of laws relating to child labor.

Board: The governing board consists of 23 men and 5 women.

Territory: The work of the Committee is national in scope.

Financial: The total budget for the year amounted to \$119,000 and the Committee is supported by memberships and contributions.

NATIONAL CHILD WELFARE ASSOCIATION, INC.

Organized 1912. Incorporated 1914.

Aim: So to educate children, parents and public, as to promote bodily health, mental effectiveness, and moral power in the children of America.

Board: The Association is governed by a board of 10 men and 4 women.

Territory: The work of the Association is national in scope.

Staff: General secretary, assistant treasurer, research secretary, director of educational service bureau, extension secretary, associate extension secretary, and clerical assistants.

Type of work: The Association originates and distributes at cost educational posters, pictures, lantern slides and other graphic material, also pamphlets and books for use by organizations and individuals engaged in child welfare work. It likewise supplies expert advice, exhibits, speakers and organizers on all phases of child welfare.

Financial: The Association is supported in part by money received from the distribution of material and in part by private contributions and membership dues.

NATIONAL FEDERATION OF DAY NURSERIES

Organized April, 1898.

Aim: To unite in one central body day nurseries that meet the requirements of the Federation, and to endeavor to secure the highest attainable standard of merit.

Board: The governing board consists of 16 women.

Territory: The scope of the organization is national and covers every city where there is a day nursery.

Staff: Executive secretary and clerical assistants compose the staff.

Type of work: Improving and standardizing day nurseries is supervised by the central office with the assistance of chairmen of local Associations where organized. The work emphasizes care for health and dietary and modern methods of education.

The work is primarily for the pre-school child.

Financial: The budget for the year was \$4,000. The organization is supported by dues and personal contributions.

NATIONAL LEAGUE OF NURSING EDUCATION

Organized 1893.

Aim: To consider all questions relating to nursing education; to define and maintain in schools of nursing throughout the country minimum standards for admission and graduation; to assist in furthering all matters pertaining to public health; to aid in all measures for public good by cooperating with other bodies, educational, philanthropic and social; to promote by meetings, papers and discussions, cordial professional relations and fellowship and in all ways to develop and maintain the highest ideals in the nursing profession.

Board: The governing board consists of 16 women.

Type of work: Educational by putting into operation those measures included under "Aim." Its headquarters, 370 Seventh Avenue, New York City, acts as a distributing center of advice upon all matters relating to nursing education. In addition, a Placement Bureau is maintained at headquarters. This Bureau represents an important activity of the League in that it forms a medium of exchange for positions between schools of nursing, hospitals and nurses.

Financial: The National League of Nursing Education is supported by membership dues and contributions from individuals and organizations.

General statement: Whatever has been accomplished in this country for the progress of nursing education has been largely through the efforts of the National League of Nursing Education and its representative state organizations. Its history covers definite achievements in the making of nursing a profession built upon scientific preparation and a vocation of community usefulness.

NATIONAL TUBERCULOSIS ASSOCIATION

Organized 1904.

Aim: The Association was organized for the study and prevention of tuberculosis.

Board: The governing board consists of 93 men and 8 women.

Territory: The work of the Association covers the entire United States. There are 48 constituent state associations and approximately 1,400 local associations.

Staff: The members of the staff number 44.

Type of work: The work of the Association is divided into the following lines of work: administrative, field, Modern Health Crusade, medical, seal sale, publicity and publications, statistical.

Financial: The Association is supported by membership dues, donations, and 5 per cent of the gross sale of Tuberculosis Christmas Seals, 95 per cent remaining with the state and local associations.

General statement: Among the outstanding activities of the year 1923-1924 are the following: (1) The furtherance of the work of the Medical Research Committee in securing more knowledge about the medical aspects of tuberculosis; (2) the conduct of surveys in the states of Michigan, Washington, Louisiana, Ohio and in individual cities in a number of other states; (3) the expansion of the Modern Health Crusade throughout the schools of the United States; (4) publication of a number of pamphlets and monographs, including "Tuberculosis, A Primer and Philosophy," by McLean, "What You Should Know About Tuberculosis," etc.; (5) the promotion of a plan to encourage more extensive recruiting and training of tuberculosis workers; (6) field service to the extent of 678 days; (7) statistical studies covering the special phases of work in various parts of the United States; (8) conduct and direction of the Christmas Seal sale amounting to \$4,200,000; (9) the development of a supply service on a business basis; (10) the conclusion of the Framingham Health and Tuberculosis Demonstration; and (11) the continued cooperation with other health agencies, official and non-official, in the National Health Council.

NEW YORK ASSOCIATION FOR IMPROVING THE CONDITION OF THE POOR

Organized 1843.

Aim: To provide the following service for families under its care:

1. General educational nursing.
2. Prenatal and postnatal care for mothers and babies.
3. Country outings for tired mothers and anemic children, and a convalescent home for the recovery of mothers after childbirth.
4. Scientific training in the proper selection and preparation of food.
5. Medical and nursing care for tuberculous families in their own homes.

6. An intensive community health program in one of the city's most congested districts.

Board: The governing board consists of 54 members.

Territory: The work of the Association covers the Boroughs of Manhattan and the Bronx, an urban territory with a population of approximately 3,000,000.

Staff: General director. Doctors: 4 (part-time). Nurses: 1 director, 6 supervisors, 46 staff. Dentists: 1 director, 1 full-time, 4 part-time. Director of Department of Family Welfare. Social service workers: 23. Nutritionists: 1 supervisor, 7 full-time. Clerical assistants: 53.

Type of work: Work of the Association includes home visiting, including the giving of necessary material assistance, clinics, classes, hospital care and health centers, for mothers and children. Five places are owned and conducted by the Association for the purpose of giving country outings to mothers and children.

Financial: The total budget for the year was \$925,496. Voluntary contributions support the Association.

THE NEW YORK DIET KITCHEN ASSOCIATION

Organized 1873.

Aim: To protect the lives and promote the health of babies, little children and their mothers.

Board: Forty-two members.

Staff: General and assistant directors; physicians for station conferences, 21; nurses, 15; station assistants, 7; nutrition teacher, 1; director of posture training, 1; instructor special exercise, 1; part-time volunteer assistants, 8; office workers, 3.

Type of work: Eight health stations are maintained.

Baby Welfare Work:

Physical examination and supervision of babies.

Consultations and demonstrations for mothers.

Posture training.

Home visits by nurses.

Emergency care of sick babies.

Home nursing or hospital admission arranged.

Dispensing of milk.

Child Health Work:

Physical examination and correction of defects for children of pre-school age.

Special instruction by nutrition worker.

Corrective physical exercise.

Family Health and Welfare Work:

Supervision for expectant mothers through cooperating agencies or by Association nurses.

Health instruction in homes.

Dispensary and hospital treatment obtained.

Assistance in securing relief and employment.

General statement: 6,352 babies under care; 6,200 mothers advised and taught; 325 expectant mothers under supervision; 1,637 pre-school children examined and supervised; 1,370 baby conferences held; 37,089 visits made to baby conferences; 6,557 visits made to children's classes; 20,115 visits made to homes by nurses and assistants; 331,470 quarts of milk dispensed.

NEW YORK NURSERY AND CHILD'S HOSPITAL, SOCIAL SERVICE DEPARTMENT

Organized 1823.

Aim: Hospital: Maternity and children's hospital and clinic.

Social Service: Prenatal care, supervision and follow-up of hospital and clinic children.

Boarding-Out Department: Care in foster homes of wards of city and other children.

Board: The governing board consists of 11 men and 9 women.

Territory: The organization serves an urban territory with a population of 401,000.

Staff: Superintendent. Social service: 1 head worker, 6 assistants. Clerical service: 1. Boarding-Out Department: 1 head worker, 3 assistants and clerk.

Type of work: Registration and social history of all clinic and ward cases. Prenatal and postnatal follow-up educational work. Pre-school and school age corrective posture, nutrition and cardiac classes.

Financial: The total budget for the Organization was \$483,684; the total budget for the Social Service Department was \$21,348. The Organization is supported by receipts from patients, public aid from the city, and donations.

STATE CHARITIES AID ASSOCIATION

Organized 1872.

Aim: The object of the State Charities Aid Association, which is a volunteer body of citizens in New York State, is to improve conditions in public charitable institutions and hospitals in New York State and to promote child care, public health, and mental hygiene.

Board: The governing board consists of 17 men and 13 women.

Territory: The work of the organization covers the entire state.

Staff: The secretary is the chief executive officer. There are 5 assistant secretaries. The staff of the departments consists of trained executives, public health workers, nurses, social service workers, field agents and volunteer visitors.

Type of work: The work of the Association, so far as it relates to children, consists of (1) maintaining a department for assisting abandoned or deserted mothers with babies or small children to secure positions where they may keep the children with them during employment; (2) maintaining county agencies for dependent children whereby committees of citizens and a paid executive cooperate with the public authorities in providing for dependent children; (3) maintaining a department for placing orphaned and destitute children in family homes; (4) maintaining a department of tuberculosis and public health which devotes special effort to preventive activities among children; (5) maintaining a mental hygiene department which devotes a substantial proportion of its efforts to providing facilities for the prevention of mental disorders among children and in providing facilities for the treatment, care, and training of children with mental diseases or defects.

Financial: It is an incorporated body, statewide, but without state aid. Its budget is about \$525,000 a year and is met in the main by voluntary contributions.

General statement: The Association has 12,000 members; it has local committees in every county. Its voluntary visitors visit and inspect all public institutions.

The Committee for Assisting Dependent Mothers with Young Children helped 1,773 women during the past year.

The Department of County Agencies for Dependent Children has been instru-

mental in organizing work in behalf of needy and neglected children in more than one-half of the counties in New York State.

The Committee on Child Placing receives orphans, foundlings and deserted children from public officials and public institutions for placement in carefully selected free homes.

The Committee on Tuberculosis is engaged in organizing, coordinating, and unifying the public health movement on the voluntary side as distinguished from the public, governmental side, particularly in work for the prevention of tuberculosis. It also exercises general oversight and supervision over the Health Demonstrations which are being carried on in Cattaraugus County and Syracuse, with the advice and assistance of the Milbank Memorial Fund.

The activities of this Committee dealing specifically with the health of children are

1. Cooperating with the Infancy, Maternity, and Child Hygiene Division of the State Department of Health.

2. Promoting the participation of local committees in the establishment and maintenance of preventoria.

3. Encouraging and assisting local committees in the establishment and maintenance of children's health camps.

4. Introducing the Modern Health Crusade into local schools.

5. Stimulating the local organization and maintenance of other lines of child health educational work.

6. Encouraging local committees to weigh and measure children.

7. Cooperating with county home bureaus and Parent-Teachers' Associations in introducing hot lunches in rural schools.

The Mental Hygiene Committee has carried on an extensive educational campaign through the distribution of pamphlet literature, the holding of public meetings and lectures, mental hygiene exhibits, conferences and newspaper publicity.

Newburgh

CHILD WELFARE COMMITTEE

Organized August, 1918.

Aim: Child health and care of mothers, also prenatal care.

Board: The governing board consists of 15 women.

Territory: The Committee serves the city with an urban population of 30,000.

Type of work: Home visiting and clinics are maintained for mothers and infants.

General statement: Two trained nurses have been placed in the field who visit daily, expectant mothers, mothers, babies and children up to school age. Instructions are given in the preparation of food for both sick and well babies. Mothers are shown how to clothe their children properly and expectant mothers are shown how to make the first baby clothes. The nurses are cooperating with the state in a program of specialization on prenatal work.

Patchogue

SUFFOLK COUNTY TUBERCULOSIS COMMITTEE

Organized September 27, 1920.

Aim: To prevent the spread of tuberculosis and to help coordinate and unify the various lines of work carried on by the public and private agencies that have points of contact with the tuberculosis problem.

Board: The governing board consists of 17 men and 12 women.

Territory: The Committee serves an urban and rural territory with a combined population of 110,000.

Staff: The Committee employs an executive secretary, a tuberculosis nurse and an occupational therapist. **Doctors:** superintendent of Suffolk Sanatorium conducts weekly clinics at the Committee's office and directs the work of the tuberculosis nurse; 7 doctors render services on occasion at a very small fee. **Dentists:** 4 dentists render service to tuberculous children who are examined at the tuberculosis clinics and who are not able to pay for it themselves, at a very small fee.

Financial: The total budget for the year amounted to \$11,000. The organization is supported by the sale of Christmas Seals.

Type of work: The Association conducts preventive, dental, and tuberculosis clinics and daily classes in occupational therapy.

General statement: The Association cooperates with the Suffolk County Tuberculosis Hospital, Board of Child Welfare, American Red Cross, Sanitary Supervisor.

Rochester

ROCHESTER GENERAL HOSPITAL AND DISPENSARY

Organized: Hospital in 1864. Dispensary in 1888.

Aim: To maintain public hospital in the City of Rochester.

Board: The governing board consists of 27 men and 25 women.

Territory: An urban population of 300,000 is served.

Staff: Medical Director, director of the dispensary. **Doctors:** 4 part-time, 25 part-time volunteers. **Nurses:** Director, 20 supervising, 130 staff, 6 graduates and 3 students in the dispensary. **Dentists:** 2 part-time, 1 volunteer. **Social workers:** 2 full-time. **Nutritionists:** Director, 1 part-time. **Clerical assistants:** 2. **Volunteers:** 4.

Type of work: Hospital care, home visiting and clinics for infants, children and adults; diagnostic, mental, visual and dental clinics are also conducted.

Financial: The total budget amounted to \$450,000. In this amount \$20,000 for dispensary work is included. Dispensary charges are 25 cents for the first visit, 10 cents for subsequent visits, and \$1 for X-rays.

During the past year 6,284 patients made 29,438 visits. In the maternity ward 381 mothers were cared for. The hospital cooperates with the Social Welfare League, Baden Street Dispensary, Homeopathic Hospital and Convalescent Home.

THE TUBERCULOSIS AND PUBLIC HEALTH ASSOCIATION OF ROCHESTER AND MONROE COUNTY

Organized November, 1917.

Aim: To promote and carry on such educational, preventive and relief work as shall contribute to the improvement of health with special emphasis on the prevention and control of tuberculosis.

Board: The governing board consists of 4 officers, an Executive Committee of 10, and 5 honorary members.

Territory: The Association serves an urban territory with a population of 325,000 and a rural territory with a population of 55,000.

Staff: Executive secretary. **Doctors:** 1 supervisor, 5 part-time. **Child health and nutrition workers:** 1 supervisor, 2 assistants. **Occupational therapists:** 2 home

visits to tuberculous patients, and director of the Curative Workshop. Educational workers: 1 who devotes half-time to county work and half-time to health examinations, 1 who handles exhibit material and educational supplies, and outside work. Three others for part-time as needed. Clerical assistants: 3.

Type of work: Health education, child health service, nutrition classes, occupational therapy, fresh air and ventilation, and health examination service.

Financial: The budget for the year was \$35,000, net. The Association is supported by the Community Chest for city work and by the sale of Christmas Seals for county work.

Utica

BABY WELFARE COMMITTEE OF UTICA, INC.

Organized 1912. Incorporated 1915.

Aim: To reduce the infant mortality of Utica and to increase the health and vitality of its children.

Board: The governing board consists of 28 women.

Territory: The organization serves an urban territory with a population of 104,210.

Staff: Doctors: 1 director, 9 part-time, 2 of whom are volunteer. Nurses: 7 staff.

Type of work: Home visiting, clinics and classes are conducted for prenatal cases, infants and pre-school children. Four health centers are maintained. Little Mothers' Leagues are organized.

Financial: The total budget for the year was \$14,000. The organization is supported by an appropriation from the city, and an annual spring drive.

OHIO

Cincinnati

BABIES' MILK FUND ASSOCIATION

Organized January, 1919.

Aim: To promote health and welfare of infants and children of pre-school age through child hygiene, dental and prenatal clinics; also obstetrical and postpartum care in home when necessary.

Board: The governing board consists of 17 men and 7 women.

Territory: The Association serves an urban territory with a population of 401,247.

Staff: The staff consists of 17 graduate nurses, 13 physicians (1 full-time, others part-time), 5 clerical workers, 1 half-time dentist and 1 dental attendant, 1 brace maker.

Type of work: The Association operates 6 child hygiene clinics, 4 prenatal clinics, 1 dental clinic, 1 orthopedic brace shop, gives medical care in homes when children are too ill to be taken to clinic, gives bedside care to obstetrical cases and nursing follow-up and instruction in homes.

Financial: The budget for the year amounted to \$57,000, support from community chest, and contributions.

General statement: The Babies' Milk Fund Association has assumed medical supervision of six day nurseries. A clinic is held once each week in each of these nurseries. One full time nurse is present at each day nursery clinic, and either visits or communicates with these day nurseries each day.

THE CINCINNATI ANTI-TUBERCULOSIS LEAGUE

Organized April 8, 1909.

Aim: Assisting in establishing and maintaining new facilities and institutions for the prevention of tuberculosis. To investigate local conditions and to educate the public regarding the nature, treatment and prevention of the disease, and to bring into cooperation existing organizations and institutions for that purpose.

Board: There are 26 men on the governing board.

Territory: The League serves an urban population of 433,000 and a rural population of 60,000.

Staff: Nutrition worker, industrial lecturer, handicap supervisor, motion picture operator, social service worker, office secretary and superintendent.

Financial: The budget for the current year is \$31,331, supported by the Community Chest, the Council of Social Agencies and the Norwood Service League.

PUBLIC HEALTH FEDERATION

Organized 1917.

Aim: The coordination of public health activities and of public and private agencies. To serve as a forum for frank discussion of health policies, and plans; to develop new, and to improve present standards of service, through the study of special problems; to secure the active support of the general membership of the member agencies of the Federation for the measures agreed upon by the coordinating committee.

Board: The governing board consists of 21 men and 4 women.

Territory: The work of the Federation covers the city and county, which has an urban population of 401,247 and a rural population of 61,153, making a total population of 462,400.

Staff: The staff consists of the executive secretary and an educational director.

Type of work: The Federation operates through divisional councils: cancer control, child hygiene, housing, mental hygiene, mouth hygiene, nursing, social hygiene, tuberculosis.

Financial: The total budget for the year was \$12,086. The Federation is the health branch of the Council of Social Agencies and Community Chest from which it receives its funds.

General statement: Some outstanding features of the work during the past year were: an organized effort that eliminated overcrowding at Longview Hospital for the Insane and lease of the hospital by the state, active assistance in bringing about the enactment of a comprehensive zoning ordinance for Cincinnati, direction of a comprehensive survey of hospital facilities in Metropolitan Cincinnati, formulation of health and mental hygiene standards for boarding homes and for child caring institutions, cooperation with Health Department and Negro Civic Welfare Association in conducting Negro Health Week, assistance in formulating graded health course for public schools.

Cleveland

THE BABIES' DISPENSARY AND HOSPITAL OF CLEVELAND

Organized 1906.

Aim: The object of the society shall be to limit and prevent sickness and mortality among infants and children, and to provide medical and surgical aid and nursing care for sick babies and children.

Board: The governing board consists of 12 men and 23 women.

Territory: The Society serves an urban territory with a population of 796,836 and a rural territory with a population of 943,495.

Staff: Medical director, superintendent of nurses and a general staff of physicians and nurses.

Type of work: Babies' Dispensary for ill infants and children under 14 years of age. Physical examination of pre-school children coming to the infant welfare stations of the Department of Health. Dental clinic for pre-school children. Rural infant welfare clinics held from June 1st to October 1st. Ten suburban towns were visited. Milk station for patients of the Babies' Dispensary and the prophylactic babies' station of the Department of Health. Training of medical students in pediatrics. Post-graduate training for public health nurses in pediatrics in cooperation with the University District Training Center and with Western Reserve University. Post-graduate experience in pediatrics for physicians in Cleveland who wish to improve their training in this field. Educational campaign to instruct mothers in the importance of breast-feeding, also how to stimulate and increase the breast milk. New Babies' and Children's Hospital will be completed in June, 1925. Capacity 150 beds.

Financial: The total budget for the year was \$90,363. The hospital is supported by the community fund, direct contributions, fees, endowment.

BUREAU OF CHILD HYGIENE, DIVISION OF HEALTH

Organized 1911.

Territory: The Bureau serves the City of Cleveland with a population of 888,519.

Staff: Physicians: Chief of Bureau on full-time, 19 on part-time. Nurses: director and assistants, supervisors and field nurses, 93 in all, do generalized nursing which includes child hygiene, communicable disease and tuberculosis; 35 clerical assistants do generalized work in these three bureaus.

Type of Work: Fifteen infant welfare stations equipped for prophylactic work for infants principally under 15 months of age. Doctors and nurses during conference hours. Good milk supplied to babies under 15 months in cooperation with the Babies' Dispensary and Hospital, a private organization. Infant eye and trachoma work, prevention of blindness, supervision of midwives, approval and supervision of boarding homes for children, day nurseries and maternity hospitals. Nurses follow up in homes. Nurses also follow up sick babies attending the Babies' Dispensary. Prenatal cases are carried by nurses only until they can be transferred to other organizations.

Financial: Budget by city appropriation. Of the loss on milk of \$12,773.91 the city paid \$10,000 from the appropriation, and \$1,773.91 was paid by the Babies' Dispensary. No fees except one of \$1 or less for demonstration of milk modifications where parents are able to pay.

General Statement: The Bureau cooperates with the Babies' Dispensary and Hospital, State Department of Health, State Board of Charities, Cleveland Humane Society, Cleveland Mouth Hygiene Association.

CHILDREN'S AID SOCIETY CLINIC

Organized July 5, 1922.

Aim: The early recognition and treatment of conduct disorders in children.

Board: There are 20 members on the governing board.

Territory: The territory served has an urban population of 1,230,000, and a rural population of 20,000.

Staff: Psychiatrist, psychologist, medical interne, and 2 social workers.

Type of Work: Observation, diagnosis and treatment of conduct disorders.

Financial: Funds are derived from the Children's Aid Society and the Community Fund. The budget for the current year is \$31,932.

General Statement: The children received into this institution are given a complete mental and physical examination. Observation made of conduct disorders and medical treatment is given when required.

CHILDREN'S BUREAU

Organized April 1, 1921.

Aim: To investigate and plan for each child seeking admission to a child caring agency or institution in Cleveland, furnishing the social facts to their admission committee for decision, supervising families of admitted children and planning their return to their own family, or to normal family life in other homes.

Board: The governing board consists of 11 men and 38 women.

Staff: Executive secretary; 2 case supervisors; 20 case workers; 4 stenographers, and 1 clerk; medical director; 2 psychiatric social workers.

Type of Work: The Bureau does case work with children either placing them in institutions, doing follow-up work in their own homes or referring to child placing agency for care in free, adopted or boarding homes. It provides medical examination and care for dependent children in institutions and boarding homes.

Financial: The budget for the year was \$54,000. The Bureau is supported by the Community Chest.

General Statement: The organization is the central planning and inquiry bureau for Cleveland's needy children, particular emphasis being placed upon investigating requests for admission to Cleveland's twenty-five institutions for dependent children. A special medical clinic has been organized at a hospital to provide thorough examination and follow-up work on children going to institutions and boarding homes. An old children's institution has been reorganized to provide special, medical, psychological, psychiatric, and observation study and planning for problem and subnormal children. Also operates during the summer months, the summer camp registry for registration and placement of needy children in summer camps.

THE CHILDREN'S FRESH AIR CAMP AND HOSPITAL OF CLEVELAND

Organized 1889.

Aim: To receive, care for, nurse, treat medically, and provide generally for weak, sick, indigent children, and to give needed instruction to their mothers.

Board: The governing board consists of 19 men and 6 women.

Territory: The organization serves an urban territory with a population of 888,519.

Staff: Superintendent of the organization, 1 doctor, 1 dentist, 2 nurses, 1 dental hygienist, 1 dietitian, 1 clerical assistant, 3 children's supervisors, 5 motor service volunteers.

Type of Work: Year around preventive care is given children between 6 and 12 years of age, who are referred by other social agencies in the community. Work conducted as a health school having 24 hours daily control of the children. Co-operation of the Board of Education and the Public Library makes the work more efficient.

Financial: The budget for the year was \$49,035. The organization is supported by the Community Chest, endowment funds, private contributions, and fees, which are regulated according to the ability of families to pay.

General Statement: During the year the average length of stay was 88 days. The daily average cared for was 85 children; 714 dismissed children returned for the Saturday morning health classes in which re-weighing and re-measuring of the child revealed his ability to continue good health habits at home.

CLEVELAND ASSOCIATED CHARITIES

Organized: 1900.

Aim: To develop family life through securing for each family from the community full opportunity for health, education, work, play and spiritual influence, initiating mass reform movements, and aiding in their application to individuals.

Board: There are 19 men and 7 women on the governing board.

Territory: The organization serves a territory with an urban population of 796,836 and a rural population of 80,000.

Staff: General secretary, assistant general secretary, supervisor of districts and auditor of case work. Social workers: 90, including 4 home economists. Clerical assistants: 43. Volunteer workers: 9.

Type of Work: Home visiting, preventive and educational.

Financial: The organization is supported by the Community Chest chiefly, with about one-ninth of its income from miscellaneous sources. The budget for the current year is \$541,000.

General Statement: In addition to the general preventive work done by all workers, there are the home economists who do more intensive health work. Through their special training in dietetics, they are able to give mothers needed lessons in the selection of right foods, the proper balance of diet, sick diet needed by certain children, and the proper way of preparing food. In addition to working with individual families and advising other workers on matters of food, the home economist does follow-up work with the mother in the home as well as the work with children and their mothers in class.

THE CLEVELAND HUMANE SOCIETY

Organized April 3, 1873.

Aim: To protect children of every race, color, and creed from cruelty, neglect, immorality, desertion, and non-support and from the effects of illegitimacy.

Board: The organization is governed by a board of directors of 38 members and an executive committee, consisting of 11 members.

Territory: Serves an urban territory with population of 888,519; suburban 146,651.

Staff: The staff consists of an executive secretary, field secretary, case director, director of training class, attorney, part time physician, seven supervisors, thirty-eight case workers, eleven case workers in training and nineteen clerical workers.

Types of Work: Child protection, home finding and child placing. Also licenses boarding homes for State Division of Charities and supervises State children in boarding homes.

Financial: Supported largely through the Cleveland Community Fund, also through city, county and state appropriations and the interest on investments resulting from endowments.

General Statement: During the year 1923-1924 the Society gave protection

to 5,852 children. It provided 512 unmarried mothers with care and made plans for their babies. The Home Finding Department secured 382 new wage, free, boarding and adoptive homes for children. The Child Placing Department provided 795 children with care in normal family homes. In addition the Society was responsible for 611 children returned to parents or relatives or placed in institutions, making a total of 1,406 children under care. The Society also supervised 129 children, wards of the State Board of Charities in family homes.

CLEVELAND NUTRITION CLINICS

Organized December, 1920.

Aim: Teaching the methods and practice for correcting malnutrition; educating the public to the need of nutrition work, and demonstration of the work by conducting nutrition classes.

Board: The board consists of 4 men and 1 woman.

Territory: The Clinic serves an urban territory of 800,000.

Staff: The staff consists of a director; doctors: 1 part-time; also school doctors in buildings where classes are held; nutritionists: 3 full-time, 1 part-time volunteer.

Type of work: Nutrition classes for malnourished children; instruction in nutrition methods at Cleveland School of Education; general nutrition work in 2 public schools and 1 parochial school. Courses of lectures to teachers, social workers, nurses, clubs and Parent-Teacher Associations.

Financial: The total budget amounted to \$9,285. The Clinic is supported by the Community Fund.

General statement: The cooperating agencies are the Public Health and Dental Dispensaries, Hospital Dispensaries, Children's Fresh Air Camp, Associated Charities, Board of Education and Western Reserve University.

THE CLEVELAND PROTESTANT ORPHAN ASYLUM

Organized January 22, 1852. Incorporated February 22, 1853.

Aim: The purpose of the institution is to gather in homeless and dependent children, such as are sound in body and mind and prepare them for homes, either with relatives, friends, or foster parents.

Board: The governing board of managers consists of 15 women, assisted by an auxiliary board of 7 women. There is also a board of trustees consisting of 7 men of prominence in the community.

Staff: Superintendent, assistant superintendent, matron visitor, physicians, nurse, and clerk.

Type of work: Children 2 years of age, who come under the control of the institution for placement in foster homes, are boarded out in private families, those from 2 to 6 years of age are sheltered in the nursery department of the institution. The clinic at the institution supervises the weighing, charting, and dieting of the underweight children. The hospital is equipped for children who need special care for slight ailments. The children are sent to a summer camp during vacation; this is a big factor in the pursuit of better health.

Financial: The institution is fortunate in having an endowment, but receives no income from the state, county or city.

General statement: The outstanding feature in the work of the medical department has been the absence of diphtheria, not a single case having occurred among

the children during the year. This gratifying experience has been no doubt due to the systematic use of toxin-antitoxin, every child receiving three doses intramuscularly, during its stay in the observation department. In addition, throat cultures are taken and several carriers have been detected and isolated. The city health officials have been very helpful in their cooperation in the control of these cases. It is a reasonable hope that this dread disease has been conquered in so far as the institution is concerned. Advantage has been taken during the year of recent studies in the prevention of goitre. Cottages are being erected on the organization's farm of 100 acres for the care of children and a hospital for minor operations and contagious diseases.

COUNCIL EDUCATIONAL ALLIANCE

Aim: Social Settlement.

Board: The governing board consists of 14 men and 11 women.

Territory: The Alliance serves an urban territory with a population of 1,000,000.

Staff: Headworker; 1 associate headworker. Social workers: 1 director, 9 full-time, 1 part-time, 50 volunteers. Nutritionists: 1 director.

Financial: The total budget for the year amounted to \$37,000 and is supported by the Community Chest.

General statement: The Alliance works jointly with the Cleveland Settlement Union. Main headquarters and one branch in two neglected neighborhoods of Cleveland. Maintains Summer Camp at Painesville on the Lake, Ohio; also Summer Play School.

CUYAHOGA COUNTY BOARD OF HEALTH

Organized October 1, 1920.

Aim: Public health service.

Board: There are 5 members on the governing board.

Staff: Doctors: 2. Nurses: 6. Clerks: 2. Sanitary officer.

Type of work: Home visiting, clinics, health centers.

Financial: Funds are derived from assessments in townships and villages in the county. The budget for the current year is \$30,000.

DAY NURSERY AND FREE KINDERGARTEN ASSOCIATION

Organized 1882.

Aim: To maintain day nurseries for the children of women obliged to assume the support of the family; to conduct free kindergartens; to provide medical inspection and dental care; to operate a training school for kindergarten and primary teachers.

Board: The association is governed by a board of 40 trustees and an Association membership of 130.

Territory: Urban territory with a population of 800,000.

Type of work: Provides expert care for the children while in the nurseries and kindergartens and endeavors to improve the condition of the homes to which they return.

Financial: Budget for 1924, \$94,494; Earnings, \$20,825; Endowment, \$20,669; Community Fund, \$53,000.

General statement: In order to estimate the value of day nursery work a care-

ful study is being made of the families applying for admission: the reason for the application; the need for nursery care; other resources available; duration of attendance; reason for discontinuing; improvement in the children while at the nursery; improvement in the home due to contact with the nursery.

JEWISH HOME FOR FRIENDLESS CHILDREN

Organized December, 1886.

Aim: To care for dependent and neglected children.

Board: The governing board consists of 15 men and 51 women.

Territory: An urban territory is served with a population of 900,000.

Financial: The budget for the year amounted to \$21,000, and is supported by Endowment Fund and Welfare Federation.

MERRICK HOUSE DAY NURSERY AND SETTLEMENT

Organized September, 1919.

Aim: To care for the children of working mothers; to provide recreational and educational opportunities for children and adults.

Board: The governing board consists of 13 women and 7 men.

Territory: An urban territory is served with a population of 25,000.

Staff: Head resident, Junior Club leader, boys' worker and 2 assistants, 8 part-time workers, nursery supervisor, 1 assistant, 1 play teacher, medical director, dental director, 2 nurses, 1 assistant nurse, 1 office secretary.

Financial: The total budget for the year amounted to \$26,000. The organization is supported by an appropriation from the Community Fund. Average fee for a child is 10 cents a day.

PUBLIC HEALTH NURSING DISTRICT, WESTERN RESERVE UNIVERSITY

Course started 1911. District established February 1, 1917.

Aim: To prepare graduate nurses for the field of public health nursing and to offer experience in this field for a limited period to senior nurses in hospitals and to give them an appreciation of public health work.

Board: The governing board consists of 4 men and 17 women.

Territory: An urban territory is served.

Staff: The staff consists of 1 director of district, 1 director of clinics, 5 instructors in public health nursing, 3 staff nurses, 1 stenographer, 4 typists.

Type of work: Home visiting and clinics for prenatal patients, infants, pre-school children, school children and tuberculosis patients. Bedside care and instruction for generalized service, including communicable disease.

Financial: The total budget for the year amounted to \$32,557. Supported by funds from the Community Chest and city.

General statement: Number of patients cared for September, 1923, to September, 1924: Prenatal 1,128; infant hygiene 3,663; tuberculosis 507; communicable disease 1,755; eye 445; V. N. A. 901; total 8,099. Home visits 46,727. Work in parochial schools was started this year. Students observe rural work in Richland County under direction of demonstration staff of American Child Health Association.

RED CROSS TEACHING CENTER

Organized July 4, 1916.

Aim: A wider extension and more diligent dissemination of health education.

Board: The governing board consists of 20 women and 1 doctor.

Territory: The organization serves an urban territory with a population of 796,836 and a rural territory with a population of 1,022,308.

Staff: Director of the organization, assistant director, secretary, 5 nurse instructors.

Type of work: The work includes health instruction, home nursing, first aid to the injured and life-saving.

Financial: The total budget for the year was \$17,892. The organization is supported by the Community Fund.

General statement: The most potent weapon in fighting disease is public health intelligence. A general knowledge of the principles of personal hygiene and health maintenance is the foundation upon which community health must be built. The Red Cross believes that the way to accomplish this is to reach the individual directly and to have a woman in each home trained in the principles of health and home care of the sick.

The Red Cross Teaching Center has been developing this kind of work for six and one-half years. Classes are taught by graduate nurses in public and parochial schools, in women's clubs, in settlement houses, in commercial and industrial establishments, and at the Teaching Center. The courses are adaptable to the group under instruction and are designed to enable the individuals to maintain their own health and to work more efficiently in their own family circles.

THE SALVATION ARMY RESCUE MATERNITY HOSPITAL AND NURSERY

Organized March, 1892.

Aim: To care for wayward and unfortunate girls and their dependent children.

Board: The hospital is governed by a board of 6 men and 1 woman.

Territory: The work of the organization covers the entire state.

Staff: Superintendent, medical director, five doctors part-time (volunteer), director of nursing service and supervising nurse.

Type of work: Hospital care is provided for girls who come to us in a pregnant condition.

Financial: The budget for the year was \$7,300. The Home and Hospital are supported partly by the Welfare Federation. Fees are regulated for each patient.

SOCIETY OF THE HOME OF THE HOLY FAMILY

Organized March 14, 1895.

Aim: To care for homeless and dependent children, giving them home training.

Board: The governing board consists of 4 women.

Territory: The Society serves the city with an urban population of 1,040,000.

Staff: The staff consists of an executive, 3 doctors, volunteer part-time, 1 clerical assistant, 4 volunteers.

Type of work. Classes are held for pre-school, school, adolescent, and dependent children.

Financial: The total budget amounted to \$12,071 and is supported by contributions and the Community Chest.

VISITING NURSE ASSOCIATION OF CLEVELAND

Organized 1902.

Aim: To give trained nursing service to the sick in their homes on a visit basis; instruction in personal hygiene, prevention of disease and value of health. In cooperation with other agencies to adjust relative social problems.

Board: The governing board consists of 5 men and 39 women.

Territory: An urban territory with a population of 805,422 and an adjacent population of 42,528.

Staff: Nurses: 1 superintendent; 1 associate superintendent; 5 supervisors; 51 staff; 1 office secretary; 1 record clerk, 5 stenographers.

Type of work: Home visiting; 1 prenatal and postnatal clinic affiliating with maternity Hospital.

Financial: Actual budget for 1923 was \$121,139.57. The organization is supported by the Community Fund, fees for nursing service and income from endowments.

General statement: During the year 1923 the nurses gave care to 16,876 patients, making 115,675 visits.

Columbus

THE OHIO STATE ASSOCIATION OF GRADUATE NURSES

Organized 1904.

Aim: The advancement of the educational standard, the furtherance of the efficient care of the sick, maintenance of the honor and character of the members of the nursing profession; and the fostering and promotion of cordial relations between the graduate nurses of Ohio and those of other states and countries.

Board: The governing board consists of 9 women.

Territory: The Association covers both urban and rural territory with a population of 5,739,394.

Financial: Supported by membership dues. The budget for the year was approximately \$4,000.

East Cleveland

EAST CLEVELAND CHILD WELFARE ASSOCIATION

Organized May, 1921.

Aim: To conduct East Cleveland Babies' Dispensary for children of pre-school age.

Board: The governing board consists of 4 men and 11 women.

Territory: The territory covered is urban with a population of approximately 30,000.

Staff: Doctors: 2 part-time. Nurses: 1. Helpers: 1 part-time. Dentists: 1 part-time. Volunteer workers: 2 part-time.

Type of work: Home visiting, clinics and health centers are maintained for infants and pre-school children.

Financial: The budget for the year was \$5,000. The Association is supported by the Community Chest.

General statement: From September 1, 1923, to August 31, 1924, 2,113 patients visited the clinic. There were 356 new patients; 101 clinic days; 116 diphtheria toxin-antitoxin inoculations; 72 vaccinations against smallpox; 1,857 home visits made by nurse; 113 patients given home care.

Eaton

PREBLE COUNTY BOARD OF HEALTH

Organized 1920.

Aim: Disease prevention and health education. Under Hughes and Griswold Act.

Board: The governing board consists of 5 men, of whom 3 are doctors and 2 are laymen.

Territory: The territory is rural with a population of 23,238.

Staff: Health Commissioner, public health nurse, clerk.

Type of work: Generalized nursing, school, preventive and educational, pre-natal, infant and child welfare. Tuberculosis clinic and follow-up work, and communicable diseases.

Financial: Funds are derived from the county and state. The Budget for the current year is \$7,500.

Toledo

TOLEDO DENTAL DISPENSARY ASSOCIATION

Organized October 20, 1920.

Aim: To maintain free dental dispensaries for such children and adults in Toledo as are financially unable to pay for dental care; to provide, as the opportunity arises, branch dental units for the Toledo schools, and to use every reasonable means to carry on a propaganda tending to increase knowledge in the value of oral hygiene.

Board: The governing board consists of 13 men and 7 women.

Territory: The Association serves an urban population of 270,000.

Staff: Executive secretary, supervising dentists on Board of Directors, 1 full-time dentist, 2 part-time dentists, 1 dental assistant.

Type of work: Prophylaxis treatment, extraction, and fillings, educational work through the distribution of booklets on the care of the teeth, dental films; tooth brushes and tooth paste are distributed when necessary.

Financial statement: The total budget is \$7,200. The salary of 1 part-time dentist is appropriated by the Board of Education in addition to this. The budget income is derived from the Community Chest and contributions. A small fee is charged in cases where the family's income seems to warrant it.

General statement: During the past year 1,392 new patients were admitted and 329 cases were reopened. Of the patients, 79.2 per cent were children.

THE TOLEDO DISTRICT NURSE ASSOCIATION

Organized 1901.

Aim: To provide home nursing for the sick of Toledo.

Board: The governing board consists of 21 women.

Territory: The territory served is urban with a population of approximately 252,370.

Staff: Doctors: 1 supervisor, 40 volunteers. Nurses: 1 supervisor, 3 supervising, 31 staff. Social worker: 1. Nutritionists: 2. Vocational worker: 1.

Type of work: Home visiting and clinics form the greater part of the work. Mothers and infants are cared for particularly. Obstetrical cases, mental, cardiac, orthopedic, tubercular, and occupational therapy patients are served. Preventive and educational work is emphasized.

Financial: The estimated budget for the year was \$87,831.77. The Association is supported by the Community Chest and fees.

General statement: The Association has added a worker to do follow-up work on infantile paralysis and is carrying on posture work. School work is under the supervision of the board of education.

OKLAHOMA

Oklahoma City

OKLAHOMA CITY PUBLIC HEALTH NURSING ASSOCIATION

Organized December, 1920.

Aim: First: Prevention of disease; Second: Provision of skilled nursing care for the sick in their homes.

Board: The governing board consists of 8 men and 1 woman.

Territory: The Association serves an urban territory with a population of 125,000.

Staff: Superintendent of nurses. Supervisor. Field nurses: 8. Secretary. School nurses: 3.

Type of work: General public health, including bedside care.

Financial: Funds are derived from the city, the Board of Education, and the Community Fund.

OKLAHOMA PUBLIC HEALTH ASSOCIATION

Organized April 23, 1917.

Aim: To provide health education.

Board: The Association is governed by a board of 40 men and women.

Territory: The work of the Association covers both urban and rural territory with a population of 2,000,000.

Staff: Managing director; 1 director and assistant for school educational work; 2 field nurses; 2 clerical assistants.

Type of work: Among schools, direction and propagation of the Modern Health Crusade, distribution of literature and aids to the teaching of hygiene to teachers throughout the state, and the conduct of stunts and health pageants. The field nurses are loaned to counties not having sufficient funds for full time nursing service for the purpose of inspecting school children and preparing for a clinic. These nurses go to our poorer communities for from one week to two months depending upon the amount of time the community can pay for. A volunteer staff of specialists give their services for occasional clinics in such communities.

Financial: The total budget for the year was \$30,000.

TUBERCULOSIS SOCIETY OF OKLAHOMA CITY

Organized March, 1918.

Aim: Health education among children and adults; the promotion of better and more extensive health service among volunteer and official health agencies of the city; the prevention and limitation of tuberculosis.

Board: The governing board consists of 12 men and 4 women.

Territory: The Society serves the cities of Oklahoma City and Edmond with populations of 105,000 (est.) and 3,000 respectively and the county of Oklahoma, including county towns, with a population of 35,000.

Staff: Executive secretary. Physicians: 1 chief of clinic, 4 associates (all

volunteers). Nurses: 1 full-time. Dentist: 1 part-time volunteer. Department heads: 1 director of Modern Health Crusade. Clerical assistants: 2.

Type of work: Nursing inspection in all rural schools, with the Modern Health Crusade in all county and city schools. A tuberculosis dispensary is maintained with free service in the form of examinations, laboratory work, and follow-up in the home. A nominal charge of \$2 per plate is made for X-ray, where the patient is able to pay. The Society is active in the distribution of health literature, delivering of health lectures, organization of county health committees and promotion of health activities among other organizations. Much of its work is carried on through committees from its board of directors, and through the Public Health Committee of the Chamber of Commerce.

Financial: The total budget for the year was \$17,833.32. Of this amount \$3,500 was for the support of its national and state affiliated agencies, from whom adequate returns were received in service and promotion of health activities in un-organized territory. The Society's support came from the sale of Tuberculosis Christmas Seals and appropriation from the Community Fund.

General statement: The city tuberculosis nursing and the dispensary nursing service is carried on for the Society by the Public Health Nursing Association. The Society makes a point of cooperating to the greatest possible extent with all other agencies.

Tulsa

TULSA COUNTY PUBLIC HEALTH ASSOCIATION

Organized 1918.

Aim: Health education, prevention of disease and corrective work.

Board: The governing board is composed of 25 men and 7 women.

Territory: The work of the Association covers both urban and rural territory.

Staff: Supervisor of medical service and 3 physicians (volunteer service), secretary, supervising nurse, 5 field nurses, and a stenographer.

Type of work: Home visiting and clinics for maternal, prenatal, obstetrical, postnatal and tuberculosis patients, infants and pre-school children; health crusades and regular inspection and corrective work in the county schools.

Financial: The Association is supported by the sale of Christmas Seals, City and Community Chest. Budget \$22,000.

OREGON

Portland

BUREAU OF CHILD HYGIENE, STATE BOARD OF HEALTH

Organized January 1, 1922.

Aim: The Bureau was organized to stimulate, encourage and further activities in maternal, infant, and child hygiene and welfare.

Board: The governing board consists of 6 physicians.

Territory: The work of the Bureau covers an urban territory with a population of 400,000, and a rural territory with a population of 380,000, a total population of 780,000.

Staff: The staff consists of a physician, an office secretary, 10 general staff nurses and 1 special nurse.

Type of work: Establishment of maternal, infant and child welfare clinics;

issuance of prenatal advisory letters; distribution of literature on maternal and child care; newspaper publicity; lectures before organizations and clubs; supplying individuals and organizations with information material on maternal and child welfare; affiliation with University of Oregon School of Social Work for Field and Lecture Service.

Financial: The budget for the past year was \$13,124. The Bureau is supported by state and federal appropriations.

General statement: The Bureau of Child Hygiene began operation from the first of April, 1922. During that period 2,000 prenatal letters have been sent out, 90,000 pamphlets distributed, 108 lectures given, 4,425 children examined, 225 clinics held by staff; 15 new clinics and 4 new prenatal clinics established; 6,500 birth registration certificates were issued. All work is carried on in cooperation with public health nurses in counties and cities, health associations, women's organizations, and schools, and local physicians.

VISITING NURSE ASSOCIATION

Organized 1902. Incorporated 1913.

Aim: To give bedside care, prevent disease, and promote community health.

Board: The governing board consists of 18 women.

Territory: The work of the Association covers the city. Portland is a city of scattered population, making the transportation problem of serious concern. There is also a large floating population which, during the winter months, establishes itself in the outlying districts.

Staff: Superintendent, general supervisor, tuberculosis supervisor, prenatal supervisor, infant welfare supervisor. District nurses, 11. Clerical assistants, 2.

Type of work: Bedside care is given maternity, acute, chronic, contagious and tuberculous cases. Prenatal work has been organized since February, 1924, in connection with the University of Oregon Medical School and a prenatal supervisor has been added to the staff. There are four prenatal clinics held each week, in different districts of Portland. Instructions are given on the home care of tuberculosis and provision made for sanitarium care. There are three infant welfare centers, in which there are five clinics held weekly. In the spring and fall of the year, a special infant welfare clinic is held in each of the districts having no regular clinic. The Association cares for all babies handled by them in maternity cases for one year. The Association refers pre-school nutrition cases to the nutrition clinic of the Portland Free Dispensary and does follow-up work for the clinic in the homes of school children. The nurses arrange for the correction of physical defects in pre-school children and cooperate with the school nurse in arranging for medical and surgical treatment of school children.

Financial: Budget for 1925, \$38,000. Association is supported by the Community Chest, appropriation from the city, dues, donations, fees, and payments from Metropolitan Life Insurance payments.

General statement: Total number of patients cared for during year: 6,712. Total number of home visits: 32,943.

PENNSYLVANIA

Berwick

AMERICAN RED CROSS, GREATER BERWICK CHAPTER, NURSING SERVICE

Organized November, 1917.

Aim: General public health program.

Board: The governing board consists of 8 men.

Territory: The Chapter serves a territory with a population of 14,000, 6,000 of which is urban.

Staff: Doctors, 1 nurse, 1 lay assistant.

Type of work: Home nursing care for maternal, prenatal, obstetrical and postnatal cases; infants, pre-school and adults. School nursing. Three baby welfare stations. Mental clinic.

Financial: Funds are derived from the Community Chest, American Car and Foundry Welfare Association, Board of Education, and fees.

General statement: The activities include weighing and measuring of school children, follow-up work of medical inspection, and care of tuberculosis patients.

Bethlehem

CITY OF BETHLEHEM, BABY HEALTH STATION

Organized 1915. Operated during summer months only. Year round service started 1917.

Aim: To prevent infant mortality, and to teach health principles generally, stressing mainly the care of the child up to school age.

Board: The governing board consists of a President, Vice-President, Secretary and Treasurer, and sixteen directors, men and women. The Commissioner of Public Safety of the City and the Executive Secretary of the Community Chest are ex-officio members of the Board of Directors.

Territory: The City of Bethlehem and vicinity is covered.

Staff: The staff consists of a superintendent, three nurses and three volunteer doctors.

Objects: To be a service center for all those wishing professional advice and assistance in the care and general development of babies and young children.

To furnish such professional services in the home or at the stations as might be required.

To support and maintain a competent organization fully qualified to carry on the work of the station.

General statement: The Baby Health Station receives notifications of births from the Registrar of Vital Statistics as soon as they are reported to him by the doctors and midwives. The nurse then makes an immediate visit to the home of the newborn. The condition of the home, mother, and infant is reported. The mother is advised as to the importance of breast feeding, regular feeding, the dangers of over-feeding, importance of fresh air, daily baths, etc. The importance of steady uninterrupted growth with a steady gain in weight is stressed and the mother strongly urged to make regular visits to one of the various clinics to make sure that the baby is developing normally. Six baby health clinics are held weekly in different parts of the city, while the main station is open every day except Saturday from 9 to 5.

Financial: The Station is supported by the Community Chest with an appropriation from the city. No fee is charged for baby health work.

Erie

ERIE ANTI-TUBERCULOSIS SOCIETY

Aim: Educational, health propaganda, cooperation with the State Health Department and local organizations for building health and preventing tuberculosis.

Board: The governing board has 6 members. There are 24 members of the Board of Directors.

Territory: The population is urban and rural, totaling 103,000.

Staff: Executive secretary, office secretary, half-time.

Type of work: Educational and propaganda. Follow-up work in county schools in addition to furnishing speakers, health exhibits, etc. Financing expenses of state clinic (Dispensary No. 3). The physicians and nurses are paid by the state, and the Society is responsible for rent, light, heat, cleaning, laundry and telephone, and the salary of a half-time clinic secretary.

Financial: The budget depends on the sale of Christmas Seals.

Philadelphia

THE BABIES' HOSPITAL OF PHILADELPHIA

Organized June, 1911.

Aim: To provide treatment and care for sick babies; to instruct and train suitable persons in the duties of caring for babies; to institute plans and means for the study, prevention, and care of disease in early life.

Board: The governing board consists of 17 men and 4 women.

Territory: The Hospital serves an urban territory with a population of 1,823,779. The out-patient and social service departments, in addition to covering the home territory of hospital patients, does intensive work in the ward in which the dispensary building is located.

Staff: The staff consists of a superintendent, who is also a director of nursing service, 1 to 3 internes, 3 to 8 graduate nurses, and 3 to 10 pupil nursery-maids, head social worker and 15 visiting nurses, part-time nutritionist, part-time dental hygienist, laboratory technician, part-time druggist.

Type of work: Started as a summer hospital in the country. Is now conducting, in addition, an out-patient department in the congested district of the city, with clinics and health centers for children under 6 years of age, diagnostic and prenatal clinics for mothers, emergency beds for dispensary patients, a social service and follow-up system. During the past year an out-patient obstetrical department has been added, with a full-time salaried physician who delivers, in their own homes, patients from the prenatal clinic. In connection with this department there is a summer seashore home which provides rest and instruction for mothers and health giving environment for their children.

Financial: Supported by Welfare Federation of Philadelphia. No fees charged but contributions encouraged. Budget for 1923—\$73,789.

General statement: During the year 7,957 patients made visits to the clinics. There were 16,809 dispensary consultations and 50,952 home consultations, and 320 patients were given hospital care.

THE CHILDREN'S HOSPITAL, DEPARTMENT FOR THE PREVENTION OF DISEASE

Hospital organized 1855. Department for the Prevention of Disease, 1913.

Board: The control is vested in a board of 21 managers.

Territory: Serves an urban population in the Thirtieth Ward.

Staff: Medical director, 18 doctors, dentist, psychologist, head worker, field supervisor, 8 field workers, health teacher, secretary, 60 volunteer workers.

Type of work: Nine clinics are being conducted, health, prenatal, associated medical, prophylactic dental child guidance, diphtheria prevention, prevention of tuberculosis, vaccination, and prevention of rachitis. Health education through health clubs and classes for children of all ages. Teaching center for students enrolled in the Pediatric Department of the Graduate School of Medicine, University of Pennsylvania, students from the Pennsylvania School for Social and Health Work, and pupil and affiliated nurses of the hospital. The Child Hygiene Association, which acts as a forum for the study of child health. Social service and follow-up nursing for the Dispensary and Ward patients.

Financial: Budget for year \$15,606.83, supported by contributions and hospital funds.

General statement: During the past year attendance at health clinics was 2,032, diphtheria prevention clinic, 1,516, clubs and special classes, 6,141, tuberculosis prevention clinic, 486, rickets prevention clinic, 345. Home visits made by nurses, 12,392. The Associated Medical Clinic is not included in the above figures and this clinic made a total of 5,788 examinations during the year.

COMMUNITY HEALTH CENTER

Organized March, 1921.

Aim: Diagnostic clinic, preventive medicine, and health education.

Board: The governing board consists of 8 men and 12 women.

Territory: The work of the Center covers an urban territory.

Staff: Executive secretary, 2 psychiatrists, psychiatric social worker, psychometrist, 3 doctors, part-time, dental supervisor, 2 dentists, part-time, nutrition worker, laboratory supervisor, 4 clerical assistants, and 20 volunteer workers.

Type of work: Diagnostic clinic, referring to hospitals for treatments; clinics and classes for preventive and educational work, clinics for dental and mental disease work, nutrition work and laboratory, also mental hygiene clinic for pre-school age children.

General statement: During the year May, 1923, to May, 1924, 5,118 diagnostic examinations were made by the staff. Of these 4,237 were physical examinations and 881 mental examinations, 3,393 individuals received dental treatment and 3,746 tests were made in the laboratory.

PHILADELPHIA ASSOCIATION OF DAY NURSERIES

Organized 1908.

Aim: The establishment and maintenance of the highest type of child care in every nursery, with constructive service to the family of which the child is a member.

Board: The executive committee consists of 10 women and the board of directors consists of the presidents of the 20 member nurseries.

Territory: The Association serves both urban and rural territory.

Staff: Executive secretary.

Type of work: The Association is composed of 20 nurseries, having an average daily attendance of 1,800-2,000 children ranging from 9 months to 12 years of age. The central office is interested in furthering the mental, physical, and social welfare of this group, and is an educational agency for the dissemination of progressive methods of nursery care.

Financial: The budget for the year was approximately \$3,500. The Association is supported by membership dues and the Welfare Federation.

General statement: The majority of the nurseries are now giving a complete physical examination to every child on admission, with regular weighing and routine re-examination at stated periods. Recommendations are followed up by a nursery visitor—in 11 nurseries by a trained social worker—using available hospitals, clinics or health centers. Attention is given to diet, rest and recreation with special attention to the undernourished child. The Schick Test, with cooperation from the mother, has become almost as routine as vaccination, which is compulsory. The past year has brought forth much improvement in staff, buildings and equipment. Increased interest in the general conditions of the home from which the nursery child comes is resulting in more constructive service with the family.

Through the efforts of the Association, a nursery school course is being introduced to be given by a graduate of Columbia University, New York, under the Kindergarten and Home Economics Departments of Temple University, using one of the associated nurseries for an observation center. This course is expected to raise the general tone of the work and lead to greater emphasis on the individuality of the child.

PHILADELPHIA CHILD HEALTH SOCIETY

(Formerly, The Child Federation)

Organized September 30, 1913.

Aim: Promotion of health of babies and children through research, education and demonstration with the cooperation of public and private health agencies and voluntary community groups.

Board: There is a governing board of 10 men and women and a medical advisory board.

Territory: The Society serves an urban territory with a population of 1,823,158.

Staff: Managing director and assistant, dental hygienist, nutrition specialist and clerical assistant.

Type of work: Research, demonstration in a limited area of plans for improvement, selling results to whole community and thus assuring permanence and extension through governmental or other agency.

Financial: Total budget for the year was \$19,137. The Society is supported by the Welfare Federation.

General statement: Research direct and through committees of experts. Present demonstrations: Nutrition and mouth hygiene through clinics and classes for children, prenatal and postnatal mothers and lecture courses for nurses, teachers and professional schools; Little Mothers' Leagues; pre-school examinations. Prenatal care: Effort through committees of physicians and workers and propaganda to improve character and increase amount of care given; annual survey, questionnaire and record sheet. Sanitary League: City-wide citizens group for extermination of fly and better health through cleaner city. A consulting bureau on nutrition. Information service on health films, slides and literature. Publications on nutrition, mouth hygiene, prenatal care and Little Mothers' Leagues.

PHILADELPHIA HEALTH COUNCIL AND TUBERCULOSIS COMMITTEE

Organized 1919.

Aim: Promotion of health by education and other methods. Demonstration of methods of prevention and treatment of tuberculosis. Cooperation with official agencies in similar work.

Board: The governing board consists of 19 men and 3 women.

Territory: The Committee serves an urban territory with a population of 1,900,000.

Staff: Physicians: 4 part-time making examinations among industrial workers, 7 conducting Negro clinics. Nurses: 1 assisting in industrial health work, 5 in Negro clinic work. Executives: 4 men, including director, doing executive work in the office, and field organization and education, 2 women, doing executive work in office and 2 women field workers. Office clerks and stenographers: 10.

Type of work: Health education and information service, industrial health service, child health service, Negro health service, statistical and research service and Christmas Seal sale service.

Financial: The total budget for the year amounted to \$107,000 and is supported by Christmas Seal sale.

PHILADELPHIA PEDIATRIC SOCIETY

Organized 1896.

Aim: Study of disease in infants and children and its prevention and cure; promotion of measures benefiting the health of infants and children.

Board: There are 12 members on the governing board.

Territory: The Society serves an urban population of about 2,500,000.

Staff: Officers and directors.

Type of work: Technical society.

Financial: Funds are derived from membership dues.

General statement: 1. The Society certifies all milk in Philadelphia. 2. It holds nine regular meetings a year, two of which are clinical meetings in hospitals, two with out of town speakers. Generally one meeting is held in conjunction with some special society, and the Annual Frederick A. Packard Lecture is given in April of each year. 3. A meeting is held each year with the New England Pediatric Society and the Pediatric Section of the New York Academy of Medicine.

PRESTON RETREAT SOCIAL SERVICE

Organized April, 1915.

Aim: To help mothers take better care of themselves, their children, and homes.

Board: The governing board consists of 21 women.

Territory: The work of the organization covers an urban territory.

Staff: The staff consists of a supervisor of nursing service, 2 doctors, and 1 social service worker.

Type of work: Home visiting and clinics conducted for maternity and prenatal cases. Home visiting for postnatal cases.

Financial: The organization is supported by special contributions and membership dues.

PUBLIC CHARITIES ASSOCIATION OF PENNSYLVANIA

Organized 1912.

Aim: To study all forms of social dependency, their causes and means for their prevention; to help the commonwealth in the care of its dependent wards; to represent the social agencies of Pennsylvania in state-wide matters, particularly in welfare legislation.

Board: The governing board has 37 members.

Territory: The area served has a population of about 9,000,000.

Staff: There are 5 executive officers and 5 office workers.

Type of work: A group of private citizens, state-wide in membership, independent of political control, functioning through divisions of child welfare and mental hygiene with a persistent educational and preventive program.

Financial: Forty per cent of the funds are derived from the Welfare Federation of Philadelphia, the balance from memberships and contributions throughout the state. The budget for the current year is \$37,270.

General statement: During the year ending May 31, 1924, the Association maintained, as in the past, a trained representative at Harrisburg to follow all welfare measures on behalf of the social agencies and interested individuals of the state, keeping our members and friends informed of the progress of welfare legislation by the publication, at approximately weekly intervals, of the report entitled "Social Legislation."

The Mental Hygiene Division was reorganized under the direction of an Executive Committee composed of 42 of the most active neuro-psychiatrists representing 13 communities. A five-year program of education and promotion has been energetically started.

The Child Welfare Division in response to wide-spread requests from child caring agencies has been organized with its state-wide council and executive committee. It has already made a study of the care of dependent children in 28 counties as demonstrated by the "poor law" authorities. This study published under the name of "The Almshouse Child" shows startling neglect.

A Welfare Information Bureau has been established. Its aim is to serve as a clearing house for questions and information on all phases of social welfare. It also acts as a center for the distribution of the latest pamphlets and material dealing with welfare topics.

ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN, SOCIAL SERVICE DEPARTMENT

Organized 1908.

Aim: To take care of social and medical problems of hospital and dispensary patients.

Board: The governing board consists of 14 men and 24 women.

Territory: The Hospital serves an urban population.

Staff: Director, assistant director, baby worker, children's worker, worker in Department of Preventive Medicine, secretary and stenographer.

Type of work: Medical follow-up, social service and health work. Supervision and development of the Department of Preventive Medicine. The work of this department consists of a health clinic for the pre-school child, nutrition class, well clinics for the examination of the apparently well child, vision class, posture class, heart class, Schick and vaccination clinics.

Financial: The Social Service Department is supported by the Hospital.

STARR CENTER ASSOCIATION

Aim: Improvement of physical, moral, mental and social status of the people in the community.

Board: There are 13 members on the governing board.

Territory: The population served is urban.

Staff: Physicians: 2. Nurses: 6.

Type of work: Preventive and educational. Home visiting, clinics, classes, health center, maternal, prenatal, postnatal, infancy, and pre-school work.

Financial: Funds are derived from the Welfare Federation.

THE VISITING NURSE SOCIETY OF PHILADELPHIA

Organized 1886.

Aim: To care for the sick in their own homes; to prevent sickness; and to promote health.

Board: The governing board consists of 25 members.

Territory: The Society serves an urban territory with a population of 1,800,000.

Staff: There are 106 members on the staff.

Type of work: Service is developed on a general family health basis. Therefore all age groupings and types of work are included. Work with school age children is carried on through the home. School nurses under the city do the work in the schools.

Financial: The budget for the current year is \$214,000. Funds are derived from payment for service rendered and voluntary contributions.

THE WHITE-WILLIAMS FOUNDATION

Organized 1800. Reorganized 1918.

Aim: The work in which the Foundation is now engaged is the development of a system for studying the social background and personal characteristics of the individual child in the schools in order to give him the educational and vocational guidance adapted to his needs.

Board: The governing board consists of 13 men and 13 women.

Territory: The Foundation serves the city with an urban population of 1,823,779.

Staff: The staff consists of a director, a supervisor of social workers, an assistant supervisor, a research secretary, 15 full-time social workers, 6 part-time, 5 fellows (in training), 24 student volunteers, 14 full-time clerical workers and 3 part-time.

Type of work: Vocational guidance, administration of scholarships, social case work in the schools.

Financial: The total budget for the year amounted to \$89,415.50, and is supported by interest on investments, contributions, and Welfare Federation.

General statement: The Foundation cooperates with family agencies, child-caring agencies, health agencies, hospitals, courts, protective agencies, special agencies for girls, Child Welfare League of America, and social service exchange.

Because adequate social work with school children in a city the size of Philadelphia is too great for any private organization to undertake, the Foundation is only attempting to meet the present needs of children in one of each of the different kinds of public schools, with the expectation that the Board of Public Education will ultimately take it over. Already the Board has partially taken over the Junior

Employment Service, adopting the methods worked out by the Foundation and employing some of its personnel. Through the gift of the Commonwealth Fund it has been possible to offer fellowships for training in school counseling to properly qualified applicants. This training has been done in cooperation with the Pennsylvania School of Social and Health Work. Qualifications for applicants are college education, teaching experience, and some training or experience in social work. Seven Philadelphia high school teachers, 4 men and 3 women, have been given special training in school counseling. This particular part of the plan has worked remarkably well and we feel that it is valuable publicity to get teachers already in the schools trained in school counseling.

Pittsburgh

PITTSBURGH CHAPTER, AMERICAN RED CROSS

Organized 1917.

Aim: Care of ex-service men and families; to act in case of disasters or epidemics.

Board: The governing board consists of 10 men and 10 women.

Territory: The Chapter serves the county and any district where needed.

PITTSBURGH DISTRICT DAIRY COUNCIL

Organized March 17, 1922.

Aim: To promote health and human welfare by educating the public generally as to the food value of milk and milk products, better methods of producing and distributing milk of a better quality and its proper care after reaching the consumer.

Board: There are 40 members on the governing board.

Staff: The staff includes 18 members.

Financial: The budget for the year is \$65,000. Funds are contributed by dealers and producers of dairy products.

PUBLIC HEALTH NURSING ASSOCIATION

Organized July 1, 1918.

Aim: General public health nursing program.

Board: The governing board consists of 20 women and 10 men.

Territory: City of Pittsburgh, population of 625,000. The Association also acts in an advisory and supervisory capacity to such districts in Allegheny County as have already established a nursing service.

Staff: Director, associate director, director of Child Welfare Department, director of County Nursing Service, 10 supervisors, 46 staff nurses (city), 14 staff nurses (county), 6 pupil nurses.

General statement: In addition to the nursing and instructive work done in the homes, well baby conferences, mothers' conferences, pre-school conferences, general medical and surgical clinics, prenatal and eye clinics are held in the various substations throughout the city.

A teaching center is maintained, in which three months' intensive training in public health nursing is given, and to which six of the Pittsburgh hospitals send pupils from their training schools.

There are 11 affiliations with industries whose employees receive nursing and instructive service.

A special prenatal supervisor has been added to the staff who goes to each sub-station every two weeks to instruct the nurses in prenatal visiting.

A central pre-school conference was opened in November. This is held each week, and cares for children from all sections of the city.

In the past year the Child Welfare Division has extended its services to 6,930 babies; 3,201 new babies were admitted; 54 per cent of the babies cared for have been registered at the well baby conferences; the remainder have been supervised in the home by the nurses who have given the mother general instruction in hygiene and the laws of health.

Of the 28,231 visits made, 88.6 per cent were educational, and 11.4 per cent were for nursing care. The total attendance at the conferences for the year was 9,843, the average number of babies attending conference each week, 477.

COUNTY SERVICE

Districts covered, 25.

Organization: Local nursing committees and a general county committee, made up of representatives from each local committee. This committee is represented on the central board of directors by 3 members.

The work is financed by the local committees, assisted by the Pittsburgh Chapter of the American Red Cross, and the Tuberculosis League; or by local school boards, or by the industries of the community.

Supervision is provided by the central office, which also provides a portion of the clerical work.

All county nurses are carrying out a general community nursing program, with school nursing as its main feature. At present, they are working in 56 of the county schools. Besides the routine work this year, 8 Little Mothers' League classes were conducted, 2 nutrition classes, and the supervision of the work from the Farm Bureau, and 2 well baby and pre-school clinics were carried.

County conferences are held weekly in the main office by the county supervisor.

TUBERCULOSIS LEAGUE OF PITTSBURGH

Organized 1907.

Aim: Cure and prevention of tuberculosis.

Board: The governing board consists of 21 men and 3 women.

Territory: The League covers both urban and rural territory with a combined population of 1,250,000.

Staff: consists of a medical director, a general superintendent, 4 doctors, 1 supervising nurse, 1 field nurse, 4 dispensary nurses, 1 part-time dentist, 2 social workers, and 4 clerical assistants.

Type of work: Home visiting, clinics, classes and hospital are maintained.

Financial: The League is supported by the sale of Christmas Seals, membership dues, contributions, appropriations, and special funds.

WOODS RUN SETTLEMENT DAY NURSERY

Organized September 25, 1922.

Aim: The nursery is conducted in connection with the other departments of Woods Run Settlement whose aim is cooperation with neighbors and working out the best possible neighborhood life and spirit.

Board: The governing board consists of 12 men and 8 women.

Territory: The Nursery serves an urban territory with a population of 15,000.

Staff: Executive, kindergartener, doctor, nurse, cook, woman for general work with children, part-time laundress.

Type of work: Maintenance of a day nursery. Children are examined every month by a physician and under the daily supervision of a nurse. Special nutrition work is done and the children are taught health habits. Defective children are referred to clinics for treatment and mothers instructed in the proper care of their children. A health center is conducted for mothers, infants, and children.

Financial: The budget for the year amounted to \$5,000, and is supported by membership dues, contributions, and appropriations.

General statement: The cooperating agencies are Associated Charities of Pittsburgh, Catholic Charities, Children's Service Bureau, Lillian Rest, St. John's Hospital, Public Health Nurses, Public Schools, and all departments of Woods Run Settlement.

Reading

VISITING NURSE ASSOCIATION

Organized March 25, 1909.

Aim: To give to the needy and those of moderate means good nursing care. To encourage the mother to care for her children intelligently by practical instruction and to assist the community in maintaining a good health standard.

Board: The governing board consists of 10 men and 10 women.

Territory: The Association serves an urban territory with a population, both urban and rural, of 125,000.

Staff: Superintendent, assistant, field supervisor, 25 field nurses.

Type of work: Home visiting, clinics, hospital.

Financial: Funds are derived from private contribution, from fees earned, and from the city. The budget for the current year is \$52,000.

General statement: The city is divided into districts, each nurse being responsible for patients needing nursing care in her own district. All newborn babies are visited periodically up to two years. Ten weekly baby welfare clinics are conducted, one daily clinic and three additional daily clinics during July and August. A camp is maintained for underprivileged school children for July and August. Maternity delivery service is furnished.

Swarthmore

SWARTHMORE CHAUTAUQUA ASSOCIATION

Organized 1912.

Aim: Chautauqua work.

Board: The governing board consists of 11 men.

Territory: The Association operates in 17 States and 4 Canadian Provinces, with an urban and rural territory.

Financial: Amount of budget about \$1,000,000, and supported by income from sale of season tickets.

Wilkes-Barre

VISITING NURSE ASSOCIATION

Organized November 1, 1908.

Aim: To provide skilled nursing care to the sick in their homes on a visit basis. To promote public health by instruction in the homes. To cooperate with other agencies engaged in community work.

Board: The governing board has 35 members.

Territory: The Association serves a population of about 100,000, about 76,000 being urban, and the remainder in small towns surrounding the city.

Staff: Superintendent. Nurses: 7 staff, 2 students.

Type of work: Home visiting, child welfare and prenatal clinics.

Financial: Funds are derived from patients' fees, municipalities, etc. The budget for the current year is \$12,892.

General statement: The work includes general, contagious disease, and industrial nursing, prenatal and postnatal service, and child welfare work.

York

VISITING NURSE ASSOCIATION

Organized January, 1909.

Aim: To provide a community public health nursing service.

Board: The Association is governed by a board of managers of 32 women and an advisory board of 13 men.

Territory: The work covers both urban and rural territory with a total population of 55,000.

Staff: Director, assistant director, 8 staff nurses, 3 school nurses, 1 city nurse, 1 industrial and 1 county nurse.

Type of work: Instructive visiting nursing, bedside care for prenatal, maternity, chronic, and acute cases, infant and child welfare clinics, school nursing, follow-up and weighing of children, health talks, routine classroom inspection, industrial service and county service.

Financial: The budget for the year amounted to \$28,915.74. The Association is supported by the Red Letter Day campaign, contributions, fees and appropriations from the city, county, and school board.

A total of 32,707 visits were made by the district nurses. The Department of Maternity Service cared for 534 mothers. The total area covered by our Association shows a birth registration of 1,367, or about 40 per cent of all babies born. About 20 per cent of the mothers availed themselves of the nurse's attention at the time of delivery and received skilled nursing care during the lying-in period.

The Association has been persistently campaigning against diphtheria since 1920 and the records show a decline in actual cases from 309 in 1920, to 52 in 1923. In direct ratio is the decline of diphtheria carriers and cases among the school children. In line with this work, daily campaigning is carried on for the immunization of children against diphtheria.

RHODE ISLAND

Providence

CHILD WELFARE DIVISION, RHODE ISLAND STATE BOARD OF HEALTH

Organized July 1, 1919.

Aim: Study and application of measures for the prevention of maternal and infant mortality, preparation and issuance of child health literature, suppression of diseases in young children.

Board: There are 7 members on the governing board.

Territory: The population served is about 610,000.

Staff: Director, secretary, field secretary, 3 nurses.

Type of work: Home visiting, prenatal, infancy and pre-school. Infancy and pre-school clinics.

Financial: The budget from state funds is \$20,000.

General statement: The state as a whole has not yet been covered, but regular home visits are at present being made on over 9,000 infants and children under five years of age.

PROVIDENCE CHILD WELFARE COMMITTEE

Organized November 13, 1913.

Aim: To bring together representatives from the various organizations engaged in child welfare work, medical, charitable and social.

Board: There are 2 women and 1 man on the governing board.

Territory: The population served is about 275,000.

Staff: Vice-Chairman, secretary and treasurer, supervisor of child welfare stations.

Financial: The source of funds is in membership dues.

PROVIDENCE DEPARTMENT OF HEALTH, DIVISION OF CHILD HYGIENE

Reorganized October, 1912.

Aim: Prevention of infant mortality, the protection of child life, and the promotion of child health.

Board: The Division of Child Hygiene is under the management of the Health Department, which is maintained by the City Council.

Territory: The Division serves an urban territory with a population of 244,000.

Staff: Superintendent. Doctors: 19 part-time. Nurses: 2 head, 15 staff. Dentist, part-time. Psychiatrist, part-time. Clerical assistant.

Type of work? Nursing supervision of all infants delivered by midwives in the city, of all infants in the licensed boarding homes of the city, and of such infants of unmarried mothers as are not under the supervision of private organizations. Examination by the child welfare physician of the infants and pre-school children brought to the 12 child welfare stations. Physical examination of school children by the school physicians. Mental examination of backward and atypical children by the psychiatrist. Dental examination of first and second grade school children by the dentist. Home follow-up visits by the school nurses.

Financial: The budget for the year is \$32,573. The Division is supported by an appropriation from the city.

General statement: During the year 1,203 infants were delivered by 34 registered midwives; 25 of these infants died before reaching the age of one month; 16,490

school children were examined by the school physicians, and 8,846 were found to have some disease or one or more physical defects; 78 per cent of these defects and diseases which the school physician felt should be treated received such treatment before the beginning of the next school year, thus giving 60 per cent of the total defects or diseases capable of correction or cure, corrected or cured.

PROVIDENCE DISTRICT NURSING ASSOCIATION

Organized June, 1900.

Aim: To provide trained nurses to care for the sick in their homes and to instruct members of the household in the simple rules of hygiene; to reduce maternal and infant mortality through prenatal and infant welfare work; to give proper supervision to the child of pre-school age through advisory work in the homes and at child health clinics.

Board: The governing board consists of 14 men and 16 women.

Territory: The work of the Association covers an urban territory only.

Type of work: Prenatal and delivery service, hourly nursing, supervision of children of pre-school age, advisory and nursing service in the homes to adults, infants and children, supervision of clinics. (There are special tuberculosis, mental hygiene and venereal disease services.)

Staff: The staff consists of a superintendent, associate superintendent, 2 general supervisors, 2 special supervisors (tuberculosis and child welfare), 6 supervising head nurses. In addition to these there are 41 graduates and 8 pupil nurses apportioned as follows: General service—12 graduates, 8 pupils; tuberculosis service—9 graduates; children's service—14 graduates; venereal disease—1 graduate; mental hygiene—1 graduate.

Financial: The Association is supported by an appropriation from the city, special contributions, annual donations, and Tag Day collections. The 1923 budget was \$101,000 and of this \$11,489.71 was met by fees from patients. The Association has a standardized fee system, but adjustments are made to meet the circumstances of individual families.

General statement: During the year 1,742 patients received prenatal care; 216 patients were attended at the time of delivery; 4,424 children were registered and followed as closely as possible; 444 sick baby clinics were attended by the nurses with an attendance of 5,231; 444 well baby consultations were attended, the attendance of which was 6,030; 51 prenatal clinics were attended with an attendance of 210; and 38,008 visits were made to children and 4,222 to prenatal patients.

One of the greatest elements of success is the interest in our work shown by the Child Hygiene Committee, an organization composed of pediatricians and representatives of State and City private organizations interested in child welfare. This Organization stands solidly beside our work, discussing plans and policies and helping us to grow and develop. Last year this Committee concentrated their attention or well baby conferences, and through their cooperation, three new ones were opened making the entire number 12. In one of these conferences pre-school children are examined. This is really our first step toward positive pre-school age work.

During the coming year, efforts are to be concentrated on prenatal work. An obstetrician has been added to the Committee membership, and plans are being discussed for better prenatal work, to better clinical facilities for the care of prenatal patients, and better cooperation with doctors and midwives. The Providence District Nursing Association is the only organization in Providence doing prenatal nursing.

Two special pieces of child welfare work are carried on by the Health Department, with whom we have splendid cooperation, namely, the following up of all births reported by midwives, and the inspection and following up of babies in infant boarding houses.

Aside from this, all child welfare work in Providence of children under school age is done by the Providence District Nursing Association.

RHODE ISLAND BRANCH OF THE NATIONAL CONGRESS OF PARENTS AND TEACHERS,
CHILD WELFARE DEPARTMENT

Organized 1909.

Aim: To aid all agencies which work in the interest of home and school; to secure the best physical, mental, and moral training for the young.

Board: The advisory council consists of 10 men. The executive board consists of 11 women—officers and committee chairmen.

Territory: The work of the department covers the state.

Type of work: The Child Welfare Department includes the codification of children's laws of Rhode Island, establishment of well-baby consultations and nutrition work in schools. Recreation, Needlework Guild, Social Service, Juvenile Court.

Financial: The total budget for the year amounted to \$3,000. The Association is supported by per capita fees from member clubs and by donations.

SOUTH CAROLINA

Greenville

EMMA MOSS BOOTH MEMORIAL HOSPITAL AND TRAINING SCHOOL FOR NURSES

Organized January 1, 1921.

Aim: Care of normal infants, under two years of age, sick girls of any age, and sick boys under fourteen.

Board: The advisory board consists of 11 men.

Territory: The work of the organization covers North Carolina, South Carolina, Georgia, and Florida.

Staff: The staff consists of a superintendent and 4 supervisors. Medical staff: 6 heads of departments and 15 associated surgeons and doctors. Dentists: 2.

Type of work: In addition to providing medical supervision and care for children, the organization provides clinics and hospital care throughout pregnancy to every expectant mother who can be reached and who is not already receiving medical care.

Financial: The total budget for the year was \$38,620. The organization is supported by the public and by earnings, special contributions and the Community Chest.

General statement: During the year 508 patients visited the clinics; 688 patients were given hospital care.

SOUTH DAKOTA

Aberdeen

PUBLIC HEALTH CENTER OF BROWN COUNTY

Organized 1921.

General statement: In 1922 and 1923 the pre-school children were included in the conferences.

Child welfare conferences were conducted every two weeks in Aberdeen and once a month in small towns in Brown County during 1924, with the health officer examining babies.

During 1921, 1922 and 1923 to the present time, the attendance of babies and pre-school children has been 2,195. A great many of these are return cases. Some cases come regularly from the time of three weeks of age until one year and once or twice a year after one year of age. Reports of births are obtained from the local physicians and calls are made at the home and advice given about breast feeding and care of the baby. Calls made in this connection total 612. Prenatal calls during the year ending September 30, 1924, totaled 95.

TENNESSEE

Nashville

STATE DEPARTMENT OF PUBLIC HEALTH, DIVISION OF MATERNAL AND INFANT HYGIENE

Organized May, 1922.

Aim: To promote the welfare and hygiene of maternity and infancy.

Territory: The territory served has an urban and rural population of 2,337,885.

Staff: Medical director, state supervisor of nursing, staff nurse.

Type of work: Home visiting, clinics, classes, mobile unit.

Financial: The budget for the current year is \$42,787.50, supported by federal and state funds.

General statement: The program may be divided roughly as follows:

1. Placement and supervision of field nurses.
2. Child health conferences conducted about the state by the Division.
3. General educational measures.
4. Financial cooperation with Division of Rural Sanitation and with Child Health Demonstration.

TEXAS

Austin

BUREAU OF CHILD HYGIENE OF THE STATE BOARD OF HEALTH

Organized September, 1919.

Aim: Infant, maternity, and child hygiene and welfare.

Board: The Advisory Council includes representatives from each state women's club organization.

Territory: The work of the Bureau covers the entire state.

Staff: Director. Nurses: 2 supervisors, 4 staff, 2 itinerant, 25 county. Clerical assistants: 7.

Type of work: Health centers are maintained for prenatal patients, infants and pre-school children. Both home visiting and classes for preventive and educational work are conducted. Midwife instruction, maternity home and "Baby Farm" supervision.

Financial: The Bureau is supported by state and federal appropriations, which amount to \$77,901.04.

General statement: The pamphlets published by the Bureau are: Care of the Baby (Spanish and English), Prenatal Care, Care of the Teeth, Child Health Centers, Health Hints and Jolly Jingles, What a Child Should Know, Health Rules, Prepare against Disease and Prenatal letters. The "Gleaner" is also issued which contains narrative reports of the nurses.

DIVISION OF NUTRITION AND HEALTH EDUCATION, BUREAU OF EXTENSION, UNIVERSITY
OF TEXAS

Organized 1914.

Board: The service is through the Bureau of Extension of the University.

Territory: The University Extension Campus is the State of Texas.

Staff: Director; 3 nutrition specialists.

Type of work: Child health and nutrition conferences for the pre-school child; nutrition classes and clinics for the school child; classes for mothers; classes for teachers to train them in health education; Watch-Your-Weight campaigns through fairs and exhibits; Get-Ready-For-School programs; health education programs for grade schools in cooperation with Interscholastic League; literature, lectures and exhibit material on health education; club programs on nutrition and health education in cooperation with Package Loan Library; Nutrition and Health Education Institute, held at the University for one week, is planned for workers from the state.

Financial: The Division is supported by an appropriation from the state. No fee is charged for services. The University pays the traveling expenses and salary of the workers, but the community pays the local expenses of the worker while she is in the community.

General statement: "Health and Happiness for Every Texas Child" is the slogan of the Division. The program is formulated as a means of educating the community, the school, the parents and the children themselves as to the causes and dangers of malnutrition, through health education. It is the policy of the Division to serve in an advisory capacity and to assist local communities in the development of permanent health education programs and in the organization of local facilities to make these programs function.

"Child Health is Texas Wealth."

VIRGINIA

Norfolk

THE NORFOLK CITY UNION OF THE KING'S DAUGHTERS, VISITING NURSE SERVICE,
CLINIC FOR CHILDREN

Organized 1896.

Aim: To give to the poor and those of moderate means the best home nursing possible under existing circumstances, and to give to the children of the poor, through clinics, the medical attention of specialists.

Board: The governing board consists of 30 women.

Territory: The organization serves an urban territory with a population of approximately 160,000.

Staff: Superintendent who is a nurse; assistant superintendent; infant welfare supervisor; staff nurses: 13. Financial secretary, record clerk. Children's clinics, chief of medical staff, 1; medical staff: 15 part-time free service. Dentist 1, social worker 1. Volunteer workers 10.

Type of work: Visiting nurse service for acute illness, prenatal, postpartum, newborn and infant welfare.

Financial: The total budget for the year was \$34,565. The organization is supported by membership dues, appropriations from city and state, special contributions and fees.

General statement: The different departments of the child welfare clinic are feeding, general eye, ear, nose, and throat, dental, orthopedic, and laboratory. In connection with the clinic is an operating room and children's ward where minor operations, such as removal of tonsils and adenoids, are performed. Follow-up visits in the home is a most important part of the work; these visits are made by all nurses on the staff.

Richmond

VIRGINIA STATE BOARD OF HEALTH, CHILD WELFARE BUREAU

Organized 1918.

Aim: Reduction of sickness and death among children, infants and mothers, the promotion of health and health education.

Board: The governing board (the State Board of Health) consists of 7 members.

Territory: The Bureau serves an urban and rural territory with a combined population of 2,372,940 as of 1920.

Staff: Director, Doctors: 2 full-time. Nurses: 1 director, 4 supervisors, 44 staff. Dentists: 1 director, 13 full-time. Educational directors, 4. Clerical assistants, 9.

Type of work: Advisory and supervisory; home visiting, clinics, conferences, health center and classes. Educational work in public schools and teacher-training institutions. Maternity and infancy welfare and midwife education.

Financial: The budget for the year was \$63,594. This does not include sums appropriated by counties to match headquarters appropriations. This item more than triples the budget. The Bureau is supported by the state aided by the Federal Government. There are no fees except for the dental clinics.

General statement: The affiliated agencies are the Children's Bureau, U. S. Department of Labor, and the American Red Cross.

WASHINGTON

Seattle

DIVISION OF CHILD HYGIENE, STATE DEPARTMENT OF HEALTH

Organized April, 1923.

Aim: To reduce infant and maternal mortality.

Board: The governing board is composed of the Director of Health and the State Board.

Territory: The state of Washington.

Staff: Pediatrician, full-time. Nurses: 2 full-time, 1 part-time. Clerk. Statistician.

Type of work: Preventive and educational, clinics, classes, publication. The Division operates under the Sheppard-Towner Act.

Financial: The budget for the current year is \$20,000. Funds are derived from the federal government and the state.

PUBLIC HEALTH LEAGUE OF WASHINGTON

Organized September, 1920.

Aim: The work is largely legislative.

Territory: The territory served is urban and rural with a population of about 1,500,000.

Financial: The League is supported by voluntary subscriptions from physicians.

General statement: The League represents the medical profession and co-operates with the dental, pharmaceutical, nursing, etc., professions at each session of the Legislature. It furnishes publicity and health articles regularly for about 75 Washington newspapers. It has made a campaign to introduce goiter-prophylaxis work in the schools of the state, with great success. It arranges for public health meetings, lectures, etc., wherever it is deemed advisable, and has arranged for a series of radio talks on health subjects to be broadcasted in both the eastern and western sections of the state. Its publication is "The Messenger."

WISCONSIN

Milwaukee

DIVISION OF CHILD WELFARE, HEALTH DEPARTMENT

Organized June 17, 1912.

Aim: The child welfare work shall include a study of all conditions which affect infant and child life in Milwaukee both from a sociological and public health standpoint, and also an investigation of similar work in other cities and countries and by local, municipal, and non-municipal departments and organizations, an effort shall be made by this department to better such conditions in the city of Milwaukee.

Territory: The Division serves the city with a population of 490,000.

Staff: The staff consists of the Deputy Commissioner of Health, director of medical service; doctors, 1 full-time, 3 part-time; nurses: 1 director, 3 supervising, 60 staff; dentists: 1 supervisor, 3 full-time, 3 oral hygienists, and 5 clerical assistants.

Type of work: Prenatal, infant welfare, dental, industrial, and tuberculosis

clinics are conducted. Home visiting for prenatal, infant, school, dental, cardiac, industrial, tuberculous and venereal diseases, and dependent children.

Financial: The budget for the year amounted to \$121,000.

General statement: While the chief medical director of each division is specialized in his individual line, the nursing service is generalized, one nurse responsible for all activities conducted in a given district. The department operates three sub-stations or health centers where the various clinics are conducted. Aside from these there are 14 child welfare clinics held in public and parochial schools, 2 in a social settlement, and 1 in the public library.

MILWAUKEE INFANTS' HOSPITAL

Aim: To care for medical cases, excluding contagion, up to two years of age.

Board: There are 20 members on the governing board.

Territory: The territory served has a population of 558,630.

Type of work: Home visiting, clinics and hospital.

Financial: The budget for the current year is \$27,611.71. Funds are derived from the Milwaukee Community Fund.

Racine

RACINE HEALTH DEPARTMENT

Organized 1907.

Aim: To conserve and promote the health and sanitation of the community.

Board: The governing board is composed of 3 members of the common council.

Territory: The Department serves an urban territory with a population of 65,000.

Staff: Health officer. Deputy health officer. Deputy registrar of vital statistics. Sanitary inspector. Dairy inspector. Garbage plant: Superintendent, 4 firemen, truck driver, 5 teamsters. Bacteriologist. Supervisor and 5 staff nurses. Venereal clinic physician. Dentist, part-time. Isolation Hospital: Superintendent, 4 nurses, cook, laundress, janitor, maid.

Type of work: Home visiting, clinics, classes, hospital.

Financial: Funds are derived from taxation. The budget for the year is \$75,000.

General statement: According to the City Charter the Health Department was a subsidiary of the Police Department until May, 1923, with the Chief of Police as the legal health officer. The Health Department functioned separately under a deputy health officer though its activities consisted mainly in sanitary inspections until 1917. The work is supported exclusively by taxation but cooperative arrangements are in effect whereby the Woman's Civic League, the Red Cross and the Junior League lend their services in the various phases of child health work.

HAWAIIAN ISLANDS

Honolulu

PALAMA SETTLEMENT

DISTRICT NURSING DEPARTMENT

Organized 1905.

Aim: To educate mothers, fathers and children in the proper care of themselves and their children, and to give nursing care to all who need it.

Board: The governing board consists of 16 men.

Territory: The work of the Association covers the city, with a population of 100,000.

Staff: Head Worker, 1 paid part-time doctor, 20 doctors (volunteer service), head nurse, assistant head nurse, 17 staff nurses, 2 clerical assistants, 15 volunteer workers from the College Club.

Type of work: Generalized nursing, consisting of service at delivery, post-partum and postnatal care, general bedside nursing and instructive infant welfare work. Summer camp conducted every year for 10 weeks for undernourished children. General dispensary clinic, 2 ear, eye, nose and throat clinics, 1 skin clinic, 11 baby clinics or health centers in operation, 2 prenatal clinics.

Financial: This Department is supported by private donations and United Welfare Campaign. The total budget is \$65,000 for district nursing.

General statement: The Settlement cooperates with all the social agencies in the city.

PHILIPPINE ISLANDS

Manila

OFFICE OF THE PUBLIC WELFARE COMMISSIONER

Organized May 1, 1921.

Aim: To undertake and promote all work related to maternity and child welfare; to improve the general welfare of the community and to give technical and financial aid to local (town or province) child welfare organizations.

Territory: The Office serves the entire insular territory with a total population of 10,350,640. (Philippine census, 1918.)

Staff: Public Welfare Commissioner, Chief, Maternity and Child Hygiene Division, Chief, Dependent Children Division, Executive Officer, Superintendent, Nurses' Service, Special Agent (social worker), Special Agent (social worker) part-time, Chief, General Office Section, Collecting, Disbursing and Property Officer, chief accountant, 4 stenographers, 11 clerks. Medical officers: 12 full-time, 1 full-time paid by puericulture center, 75 part-time serving puericulture centers all over the Islands. Nurses: Assistant superintendent, 17 supervisors, 44 staff, 150 full-time serving puericulture centers. Dentists: 2 part-time. Midwives: 6 staff, 28 serving puericulture centers and maternity houses. Social service: 3 social workers, artist. Institutional workers: 2 matrons, 9 teachers, 55 others, including provision buyer, caretakers of children, chauffeurs, cooks, messenger, helpers, and laborers.

Type of work: The activities are:

1. To investigate, promote, coordinate, inspect and regulate all work related to maternity, child hygiene and welfare in the Philippine Islands.
2. To study, coordinate and regulate the efforts of all government agencies and influences in public welfare or social service work and of such private agencies as are receiving government support.
3. To investigate social conditions in the Philippine Islands.
4. To provide orphaned or needy children with means for their care, as well as to provide necessary care to defective and delinquent children.
5. To give technical and financial assistance to public welfare organizations.

Financial: The budget for the year was \$564,467. The Office of the Public Welfare Commissioner is supported by an appropriation from the legislature and by special contributions.

General statement: There are 293 organized puericulture centers under the supervision of the Office of the Public Welfare Commissioner, 165 of which are actually in operation, with one or more full-time nurses and an attending physician in each. The others are not in operation through lack of funds or the inability to secure the services of a nurse. The registration in 162 centers during 1923 was: Babies and children 77,405, mothers 21,644. The attendance was: Children 294,367, mothers 56,909, others 16,213. The funds for the support of these centers are raised locally from private sources, to which the central government contributes. Local governments in some cases make appropriations as aid to these centers.

There are 3 schools of midwifery operated and supervised by the Office, and each offers a nine months' course for the purpose of qualifying a greater number of licensed midwives to substitute for the ignorant ones.

There is administered under the Office an orphanage which takes care of more than 250 children, who are provided with educational facilities in the organization

HAWAIIAN ISLANDS

Honolulu

PALAMA SETTLEMENT

DISTRICT NURSING DEPARTMENT

Organized 1905.

Aim: To educate mothers, fathers and children in the proper care of themselves and their children, and to give nursing care to all who need it.

Board: The governing board consists of 16 men.

Territory: The work of the Association covers the city, with a population of 100,000.

Staff: Head Worker, 1 paid part-time doctor, 20 doctors (volunteer service), head nurse, assistant head nurse, 17 staff nurses, 2 clerical assistants, 15 volunteer workers from the College Club.

Type of work: Generalized nursing, consisting of service at delivery, post-partum and postnatal care, general bedside nursing and instructive infant welfare work. Summer camp conducted every year for 10 weeks for undernourished children. General dispensary clinic, 2 ear, eye, nose and throat clinics, 1 skin clinic, 11 baby clinics or health centers in operation, 2 prenatal clinics.

Financial: This Department is supported by private donations and United Welfare Campaign. The total budget is \$65,000 for district nursing.

General statement: The Settlement cooperates with all the social agencies in the city.

PHILIPPINE ISLANDS

Manila

OFFICE OF THE PUBLIC WELFARE COMMISSIONER

Organized May 1, 1921.

Aim: To undertake and promote all work related to maternity and child welfare; to improve the general welfare of the community and to give technical and financial aid to local (town or province) child welfare organizations.

Territory: The Office serves the entire insular territory with a total population of 10,350,640. (Philippine census, 1918.)

Staff: Public Welfare Commissioner, Chief, Maternity and Child Hygiene Division, Chief, Dependent Children Division, Executive Officer, Superintendent, Nurses' Service, Special Agent (social worker), Special Agent (social worker) part-time, Chief, General Office Section, Collecting, Disbursing and Property Officer, chief accountant, 4 stenographers, 11 clerks. Medical officers: 12 full-time, 1 full-time paid by puericulture center, 75 part-time serving puericulture centers all over the Islands. Nurses: Assistant superintendent, 17 supervisors, 44 staff, 150 full-time serving puericulture centers. Dentists: 2 part-time. Midwives: 6 staff, 28 serving puericulture centers and maternity houses. Social service: 3 social workers, artist. Institutional workers: 2 matrons, 9 teachers, 55 others, including provision buyer, caretakers of children, chauffeurs, cooks, messenger, helpers, and laborers.

Type of work: The activities are:

1. To investigate, promote, coordinate, inspect and regulate all work related to maternity, child hygiene and welfare in the Philippine Islands.
2. To study, coordinate and regulate the efforts of all government agencies and influences in public welfare or social service work and of such private agencies as are receiving government support.
3. To investigate social conditions in the Philippine Islands.
4. To provide orphaned or needy children with means for their care, as well as to provide necessary care to defective and delinquent children.
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General statement: There are 293 organized puericulture centers under the supervision of the Office of the Public Welfare Commissioner, 165 of which are actually in operation, with one or more full-time nurses and an attending physician in each. The others are not in operation through lack of funds or the inability to secure the services of a nurse. The registration in 162 centers during 1923 was: Babies and children 77,405, mothers 21,644. The attendance was: Children 294,367, mothers 56,909, others 16,213. The funds for the support of these centers are raised locally from private sources, to which the central government contributes. Local governments in some cases make appropriations as aid to these centers.

There are 3 schools of midwifery operated and supervised by the Office, and each offers a nine months' course for the purpose of qualifying a greater number of licensed midwives to substitute for the ignorant ones.

There is administered under the Office an orphanage which takes care of more than 250 children, who are provided with educational facilities in the organization.

and with practical vocational training in different industrial and commercial establishments outside of the institution. The office has undertaken some studies on child hygiene and on the living conditions of laborers.

PHILIPPINES CHAPTER OF THE AMERICAN RED CROSS

Organized December 5, 1917.

Aim: To alleviate suffering in time of war or disaster and to prevent suffering in time of peace by promoting and engaging in an active public health program. The services in operation are Home Service, which is social service to ex-service men and their families; Junior Red Cross service which is promoting the organization of children for service; Health and Nursing service and Disaster Relief Production Room, employing poor women needing the occupation and producing garments for use of the Disaster Relief Committee, as well as for returning soldiers and sailors.

Board: The Executive Committee consists of 10 men and 3 women.

Territory: The work of the Chapter covers the entire Islands with a total population of about 11,000,000 divided among 50 branch committees, one in each province. The work in the City of Manila is for a population of about 285,000.

Staff: The staff includes a general manager, secretary of Home Service, Director of Nursing Service, secretary of Junior Red Cross, field director of Military Relief; Junior Red Cross Dental Service including 2 supervising dentists, 7 dentists in Manila, 69 in the provinces; Nursing Service consisting of 6 supervisors, 16 health nurses in Manila and 64 in the provinces.

Type of work: Clinics for prenatal, infant and child care; classes in home hygiene and care of the sick and infant care; home visiting for general nursing care and demonstration on the care and feeding of infants to mothers. Instruction of school children and instruction to mothers on the importance of having defects in their children corrected; health center for mothers and infants; instructor of unlicensed midwives.

Financial: The budget for the current year is:

Senior P 261,179.15

Junior P 240,300.00

The Chapter is supported by annual membership dues and contributions.

General statement: There are 7 dental clinics in Manila and 69 in the provinces. The school dentists treat more than 25,000 children each month free of charge. The Red Cross Nursing staff and the Red Cross physicians in Sta. Cruz and Quiapo districts, Manila, have reduced the infant mortality rate among the babies under their supervision from 52 per 1,000 to 38 per 1,000 by teaching mothers the proper care of their babies.

CANADA
PROVINCE OF ALBERTA
Edmonton
DEPARTMENT OF PUBLIC HEALTH

Organized 1918.

Territory: The work of the Department covers the whole Province of Alberta.

Staff: The Minister of Health, deputy minister, superintendent, supervisor, 12 field nurses, rural public health nurse, child welfare nurse, lecturing nurses and district nurses and one clerical assistant. Six doctors give free service for child welfare clinics.

Type of work: Generalized public health nursing, inspection of rural schools, home visits, child welfare and maternity conferences and visiting nursing, tuberculosis follow-up and social service, district nursing. Child and maternity conferences cover the prenatal period until the end of the pre-school period. Nine weekly conferences are held. Conferences in the principal cities are held with the cooperation of the cities.

Financial: The Department is supported by the Government. Total budget \$39,000. The prenatal and child welfare conferences are free to the public.

General statement: The public health nurse under the Provincial Department of Health conducts health inspection of rural school children, part-time doctor and dentist are employed for clinics in isolated districts.

An individual record system is kept, but as the school work in the cities is under the municipal authorities, our records are not continuous.

There is cooperation between the University of Alberta, City Departments of Health; Medical Schools; Relief Organizations and private groups.

There has been a decrease in infant and maternal mortality, and in deaths from tuberculosis, improved health among children, less communicable disease. The interest of parents is manifested by increased attendance at clinics.

PROVINCE OF BRITISH COLUMBIA
Victoria

PUBLIC HEALTH NURSING SERVICE

Type of work: The Public Health Nursing Service is directed from the health centers in municipalities and rural districts. Well-baby clinics, Little Mothers' League classes and medical clinics are conducted and lectures on home nursing and hygiene given. The nurses also make classroom inspection of schools.

Staff: The School Act has been amended to allow Boards of Trustees to employ public health nurses and dentists. The nurses are employed by municipalities, or several rural school districts may combine to raise the amount of the nurse's salary.

The nurses are trained in public health nursing. The University conducts a five year course leading to the degree of Bachelor of Science and Nursing. The first three are the usual nurses' training courses leading to certificate of registered nurse; the next two in public health nursing which entitles the nurse to the degree of Bachelor of Science and Nursing.

Finances: Public health nursing work is financed through taxation.

General statement: The Child Welfare Committees in British Columbia work through the Women's Institutes. A Provincial Secretary deals with the work and each Institute has a committee known as the Child Welfare Committee as one of its

active units. Yearly conferences are held at which the work for the past year is reviewed and a program for the following year outlined. These committees work in conjunction with and under the direction of the Provincial Board of Health.

The work has been carried on for three years and is now on a sound basis. The difficulty is not to find places for the nurses, but to find nurses to fill vacancies in communities where they are clamoring for such service.

As the work continues, it becomes evident that placing the nurse on the same basis as the school teacher, with salary paid through taxation, causes her to be generally recognized as a public health teacher, and not a public health nurse. The use of the term "public health nurse" is encouraged.

PROVINCE OF NEW BRUNSWICK

Fredericton

CHILD WELFARE DIVISION OF THE DEPARTMENT OF HEALTH

Organized October, 1918.

Aim: The purpose of the organization is child welfare.

Board: The organization is under the management of the Department of Health.

Territory: The work of the organization covers the entire province, which has a population of 400,000.

Staff: The regular staff of the Department of Health carries on all child welfare work, under immediate supervision of the Public Health Nursing Service Branch.

Type of work: Home visiting, clinics and classes are provided for infants and pre-school children. Hospital care is given to obstetrical patients, infants and pre-school children. Health centers and mobile units are maintained.

General statement: The cooperating agencies are: The Provincial Red Cross, Victorian Order of Nurses, Anti-Tuberculosis Society, Women's Institutes, Imperial Order Daughters of the Empire, Junior Red Cross, and St. John's Ambulance Society.

PROVINCE OF NOVA SCOTIA

Halifax

MASSACHUSETTS-HALIFAX HEALTH COMMISSION

Organized September 22, 1919.

Aim: To lower the sickness and death rates of Halifax and Dartmouth and use all possible means to do so.

Board: There are 9 members on the governing board.

Territory: Halifax with a population of 59,575, and Dartmouth with a population of 7,899.

Staff: Executive officer. Tuberculosis examiner. Laboratory assistant. Paedodontist. Secretary. Office secretaries: 3. Nurses: Chief, 16 public health, 2 clinical. Visiting housekeepers: 2. Historian.

Type of work: Preventive medicine, covering clinics by medical staff and field work by public health nurses and nutrition workers.

Financial: Funds are derived from the Massachusetts-Halifax Relief Commission and the Halifax Relief Commission.

General statement: The Commission operates two health centers and will co-operate in the Dalhousie University Health Clinic (opened in October, 1924) for which it has provided 4 public health nurses, a supervisor and record clerk. Clinics cover the following lines of work: prenatal, baby welfare, child welfare, dental, nutri-

tion, posture, eye, ear, nose and throat, tuberculosis, skin and venereal disease. They are held at the health centers. The public health nurses do no bedside work, but this service is covered by the Victorian Order of Nurses. The Commission distributes health literature, publishes weekly health talks, and in every way is educating the people of Halifax and Dartmouth in modern public health.

PROVINCE OF ONTARIO

Hamilton

THE BABIES' DISPENSARY GUILD

Organized 1911.

Aim: The charter of the Guild provides for any effort to reduce infant mortality or advance child welfare.

Board: The Guild is governed by a board of directors, with an auxiliary medical board, also a women's board, controlling material relief and supplying voluntary aid for practical work.

Territory: The Guild serves an urban territory with a population of approximately 110,000.

Staff: Supervisor of Nurses. Field workers: 5. Medical director. Doctors: 15 part-time, each of whom give from 1 to 2 hours per conference, 9 alternates to fill vacancies. Volunteer workers: 10 in active service and 9 alternates, giving from 2 to 3 hours per conference. Clerical assistant: 1.

Type of work: The work includes weekly prenatal clinics and follow-up visits for supervision and instruction in general care. Child Welfare: Weekly conferences for children up to two years of age in five depots, semi-weekly in one depot and a central station with a daily conference.

Financial: The total budget was \$12,772.39. The organization is supported by membership fees and an appropriation from the city. No fees are charged for services.

General statement: The outstanding achievements for the year are the appointment of a part-time medical director, and the erection of a building which will equal anything in the Dominion for this type of work.

Toronto

DEPARTMENT OF PUBLIC HEALTH, CHILD HYGIENE SECTION

Organized 1912.

Aim: To apply preventive medicine to the community—all types.

Board: The governing board consists of 4 men and 1 woman.

Territory: The work of the organization covers an urban population of 540,000.

Staff: The executive staff of the Department consists of a medical officer of health, a deputy medical officer of health, with directors for each of the various sections. The medical staff consists of 9 full-time physicians and 4 part-time physicians. The nursing staff includes a director, 114 nurses and 18 clerks. The dental staff consists of a director, 31 part-time dentists, and 28 dental assistants. A volunteer organization has approximately 70 members.

Type of work: The staff named above does generalized public health work. A large proportion of their time is devoted to child hygiene, including prenatal, infant, pre-school, and school work.

Financial: The organization is supported by a city appropriation. No fees are charged.

General statement: Infant mortality rate for the year 1923 was 63.

PROVINCE OF QUEBEC

Montreal

CHILD WELFARE ASSOCIATION OF MONTREAL

Organized 1917.

Aim: To promote the knowledge of child hygiene in all its phases. To encourage methods and measures to reduce maternal and infant sickness and mortality. To promote or support measures conducive to the health, happiness, and welfare of children.

Board: The governing board consists of thirty-six members, elected annually.

Territory: The Association serves an urban territory with population of approximately 300,000.

Staff: The staff consists of a director, a part-time medical director, and a nursing supervisor, 16 doctors part-time, 17 nurses, and office assistant.

Type of work: (a) Twelve health centers with conferences for infants under two years, conferences for prenatal cases. Work in centers is educational and preventive only. All sickness other than feeding disturbances referred to private doctors or to dispensaries. Educational visiting in homes.

(b) Nutrition classes in selected school.

(c) Summer day-camp for children. A nurse is in charge of the day-camp and finds many opportunities of teaching health rules to the mothers and children. She conducts a Little Mothers League. Poster classes and toothbrush drills have been held this summer. There has been an average attendance of 250 daily.

(d) Health letters sent to expectant mothers throughout the Province.

(e) Health Week for educational propaganda in the city.

(f) Weekly educational article in press.

Financial: Budget for 1924 was \$44,374. The Association is supported chiefly by voluntary contributions, through a financial federation of charitable agencies. It receives also a small grant from the Province and from the City of Montreal.

General statement: During the past year approximately 6,000 babies have received supervision in their homes and at the health centers. In the majority of these homes the nurses have given supervision and teaching necessary for all members of the family.

The organization includes four prenatal conferences under the supervision of obstetricians and a special prenatal nurse who also does most of the prenatal home visiting; approximately 350 prenatal cases have been supervised.

Pre-school conferences have been held at two of the health centers giving supervision to many school children. A special nutrition worker helps in this work by visiting in the homes and by demonstrating the making of simple foods at the conferences.

A demonstration of special nutrition work in three English and three French schools has led to the establishing of a milk lunch in many schools and to the recognition of the value of special nutrition work.

In March, 1924, a demonstration in the prevention of goitre by the use of iodostarine tablets was undertaken by this Association among the pupils of the Girls High School. In this city about three hundred and seventy-five children between the ages of 11 and 14 are taking this treatment with the consent of their parents. This will continue for several years, and is too new at the present time to give a report of the result of this demonstration.

MEXICO**Mexico****STATE DEPARTMENT OF HEALTH****THE EDUARDO LICEAGA HYGIENE INSTITUTE**

Organized October 10, 1922.

Aim: Prenatal and postnatal puericulture.

Territory: The city and districts 1, 2, 3, and 4.

Staff: The staff consists of a medical director in charge of the consulting department for pregnant women, a doctor in charge of the infant department, a doctor in charge of the test laboratory and an assistant, a midwife, 2 staff nurses, 2 visiting nurses, a lady administrator, a typist, a janitor and a servant.

Type of work: A clinic for pregnant women, an antisiphilitic clinic for pregnant women, Wassermann tests, a clinic for infants less than two years old, an instruction department for prenatal and postnatal care, social work, visits, conferences, exhibitions and competitions, propaganda for publication in the press and in the Department of Health Bulletin.

Financial: Supported by government funds.

General statement: From October, 1922, to August, 1924, 1,443 pregnant women and 3,675 infants were attended in the consulting departments.

STATE DEPARTMENT OF HEALTH**MANUEL DOMINGUEZ CHILD WELFARE STATION**

Organized September 26, 1923.

Aim: To increase health and prevent disease among pregnant women. Instruction on prenatal hygiene. To watch over and attend infants less than two years old so as to improve and preserve their health (postnatal hygiene).

Staff: The staff consists of a medical director, 2 doctors, a midwife, 2 nurses, 2 visiting nurses, a young lady in charge of the department for urine analysis, a lady administrator and a stenographer.

Type of work: Diagnosis and treatment of pregnant women, hygienic and nutritive care of infants less than two years old, antivarilous vaccination, qualitative analysis of the urine, Wassermann tests, treatment for syphilitic women and children, home visits to pregnant women and children who have failed to attend the station, theoretical and practical conferences on prenatal and postnatal hygiene.

Financial: Supported by the Department of Health.

General statement: From September 16, 1923, to September 15, 1924, 609 pregnant women and 1,150 infants were attended at the Station.

CZECHOSLOVAKIA

Prague

CZECHOSLOVAK RED CROSS

Organized February, 1919.

Aim: Activity in the domain of social hygiene, charity and relief work in case of war. Education of the youth through the Junior Red Cross.

Board: The governing board consists of 10 men and 1 woman.

Territory: The entire country with a population of over 13,000,000.

Staff: The staff consists of a director general; doctors: 1 director, 11 full-time, 32 part-time, 100 part-time volunteer; nurses: 1 director, 11 supervising, 33 staff, 1,900 registered nurses; social workers: 50 full-time, 2,305 part-time volunteers.

Type of work: Home visiting, clinics, and health centers are maintained for all ages. Mothers and children are examined at the health stations and the mothers are instructed in hygiene, children from the famine areas of Russia, transported into Czechoslovakia by the Red Cross and children of Russian refugees were clothed and fed. They were given a health examination and placed in orphanages, families, and vacation colonies, the Red Cross maintaining supervision of their health. A hospital conducted by the Red Cross at Hust is the center of the fight against epidemics. Health consultations for mothers and children and a tuberculosis dispensary are also maintained at the hospital. Vacation camps are conducted for children suspected of having tuberculosis living in an unhygienic environment. Hygiene is popularized by means of a mobile unit traveling through the districts organizing conferences on tuberculosis, general hygiene, and the care of children. The group is composed of two doctors, an agent, and a chauffeur who is also a cinema operator.

Financial: The budget for the year amounted to 22,435,050 Czechoslovak crowns.

General statement: During 1921 and 1922 there were 53,995 cases examined and given necessary instruction at the health stations. A hospital founded for the children of Slovakia by the League of Red Cross Societies was operated by the Czechoslovakian Red Cross for one year caring for 430 children in the hospital and 1,443 in the ambulances. Four hundred refugee children and 439 Russian children from famine areas received care; 1,889 children were cared for in 36 sanitary and preventive colonies. The Czechoslovakian Red Cross cooperates with the State Departments and all health, charitable and social agencies.

The Czechoslovak Red Cross organizes every year at the Easter holidays, the "Peace days of the Red Cross," during which all daily papers avoid political topics and devote their interest to questions of social hygiene. A "parliament of social workers" is being planned for the coming year.

In 1924, there were over 500,000 members, Junior Red Cross included, and over 500 local chapters.

POLAND

Warsaw

MEDICAL DEPARTMENT OF THE POLISH AMERICAN CHILDREN'S RELIEF COMMITTEE

Organized July 1, 1922.

Aim: Promoting, assisting and controlling the activity of infants' and mothers' health stations in Poland.

Territory: An urban population of over 3,500,000 is served.

Type of work: Home visiting, clinics.

Financial: The budget for the current year is \$50,000. Support is derived from the fund left by the American Relief Committee and from appropriation by the Polish government.

General statement: On December 31, 1923, there were 84 child health stations. The Department is publishing every two months a magazine "Child Welfare."

CHINA

Shanghai

COUNCIL ON HEALTH EDUCATION

Organized: The Council is the outgrowth of the combined health efforts of the Young Men's Christian Association, the China Medical Missionary Association, and the National Medical Association which was organized in 1917 under the name of the Joint Council on Public Health Education. In 1920 when the Young Women's Christian Association and the China Christian Educational Association joined, the name was changed to the Council on Health Education.

Aim: To conserve and promote health in China primarily through the constituencies of the participating organizations.

Board: The affairs of the Council are administered by an Executive Committee composed of representatives of the participating organizations.

Territory: The work of the Council is national in scope.

Staff: The staff is composed of 20 full-time workers, only 2 of whom are Americans, the rest being all Chinese. At one time it had 5 foreign workers on the staff.

Type of work: Preparation of books, pamphlets, bulletins, charts, posters, exhibits on health subjects, publication of a health magazine, "Health," distribution of slides, films and anatomical models, assisting in promoting health campaigns in various cities, lecturing on health topics, and supplying health stories to 53 Chinese newspapers in 16 different provinces. It has now 7 departments carrying on the various activities, namely, Director's Office, Administration, Business Department, Chinese Literature Department, School Hygiene Department, Child Hygiene Department, and Community Hygiene Department.

Financial: Financially the Council is supported by contributions from organizations and individuals interested in this type of work.

Provincial representatives: There are four provincial representatives, who carry on health work with independent staff and financial support in Anhui, Hunan, Kwangtung and Shansi.

■

SECOND ANNUAL MEETING
of the
AMERICAN CHILD HEALTH ASSOCIATION

SECOND ANNUAL MEETING
of the
AMERICAN CHILD HEALTH ASSOCIATION

The Second Annual Meeting of the Association was held in Kansas City, Missouri, October 14th-16th, 1924. In the absence of the President of the Association, Mr. Hoover, the third Vice-President, Dr. Wood, presided. The annual meetings of the Executive Committee and the Directors were held Tuesday, October 14th, and Thursday, October 16th.

SESSIONS

The sessions met as follows:

Tuesday, October 14th:

9:30. Meeting of Retiring Board of Directors.

10:30. General Session: Message from the President, Mr. Hoover; address by Dr. Wood, third Vice-president and presiding officer; Report of the Executive Committee, presented by the Secretary of the Association, Dr. Van Ingen; Report of the Comptroller, Mr. Flesh, also read by Dr. Van Ingen; Report of the General Executive, Mr. Courtenay Dinwiddie. Appointment of the following Committee on Resolutions: Merrill Champion, M.D., Boston, Miss Mary E. Murphy, Chicago, Borden S. Veeder, M.D., St. Louis, Frank C. Neff, M.D., Kansas City.

2:00. Election of Directors: To serve until 1929: James Ford Bell, Henry J. Burkhart, M.D., Merrill E. Champion, M.D., Taliaferro Clark, M.D., John H. Finley, John A. Foote, M.D., Elizabeth Fox, R. N., Samuel McC. Hamill, M.D., Gertrude Lane, Sara B. Place, R. N., Edgar Rickard, Frederick Davis Stricker, M.D., Allen Wardwell, Herbert B. Wilcox, M.D., Linsly R. Williams, M.D., and William C. Woodward, M.D.; to serve until 1927, Mrs. A. H. Reeve.

2:30. Training Leaders for Child Health Work.

- 3:30. Meeting of Incoming Board of Directors. Mr. Hoover was re-elected President of the American Child Health Association, Mr. Flesh was elected Treasurer of the Association.
- 7:30. Joint Meeting with Kansas City Annual Fall Clinical Conference and Medical Association of the South West Public Health Program.

Wednesday, October 15th:

- 10:00. Problems of Late Childhood and Early Adolescence.
- 2:30. Essentials of Community Organization for Child Health Work.

Thursday, October 16th:

- 10:00. Discussion of Some Special Aspects of Child Health Work.
- 2:00. Closing Business Meeting—Adoption of Resolutions.
- 2:30. Essentials of Community Organization for Child Health Work.
- 3:00. Joint Session on Pediatrics and Obstetrics with Kansas City Clinical Society.

AMERICAN CHILD HEALTH ASSOCIATION

OFFICERS

HERBERT HOOVER, *President*
 LIVINGSTON FARRAND, M.D., *2nd Vice-President*
 THOMAS D. WOOD, M.D., *3rd Vice-President*
 MRS. MAUD WOOD PARK, *4th Vice-President*
 PHILIP VAN INGEN, M.D., *Secretary*
 EDWARD M. FLESH, *Treasurer*
 CORCORAN THOM, *Washington Representative*

DIRECTORS

(Grouped according to years in which terms expire)

1925

Fred L. Adair, M.D.
 Mrs. Nicholas F. Brady
 * Edward M. Flesh
 Arnold Gesell, M.D.
 Mrs. Bryant B. Glenny
 E. J. Huenekens, M.D.
 William Palmer Lucas, M.D.
 J. Arthur McBride
 E. V. McCollum, Ph.D.
 * Mrs. William B. Meloney
 Frank C. Neff, M.D.
 Mary Swartz Rose, Ph.D.
 Margaret K. Stack, R.N.
 Ellen A. Stone, M.D.
 William H. Welch, M.D.
 Ray L. Wilbur, M.D.

1926

S. Josephine Baker, M.D.
 * George Barr Baker
 * James G. Berrien
 S. Lillian Clayton, R.N.
 Thomas B. Cooley, M.D.
 * Clinton H. Crane
 Victor G. Heiser, M.D.
 Horace Morison
 J. Prentice Murphy
 Mrs. Frederick Peterson
 Mrs. Charles S. Pillsbury
 * Watson S. Rankin, M.D.
 Lawrence T. Royster, M.D.
 Bernard Sachs, M.D.
 Richard M. Smith, M.D.
 C.-E. A. Winslow, Dr. P.H.

1927

* Grace Abbott
 Hugh S. Cumming, M.D.
 * Livingston Farrand, M.D.
 Mary Gardner, R.N.
 Clifford G. Grulee, M.D.
 * Herbert Hoover
 J. H. Mason Knox, Jr., M.D.
 Mrs. Franklin K. Lane
 Frederick Peterson, M.D.
 Mrs. A. H. Reeve
 Corcoran Thom
 * Philip Van Ingen, M.D.
 Borden S. Veeder, M.D.
 Florence Wardwell

* Thomas D. Wood, M.D.

1928

A. J. Chesley, M.D.
 Laurence R. DeBuys, M.D.
 Louis I. Dublin, Ph.D.
 Homer Folks
 Lee K. Frankel, Ph.D.
 Mrs. Lyman D. Gilbert
 Henry F. Helmholtz, M.D.
 Christian A. Herter
 Helen MacMurchy, M.D.
 Mrs. Gordon Norrie
 Mrs. Maud Wood Park
 Angelo Patri
 Henry L. K. Shaw, M.D.
 E. L. Thorndike, Ph.D.
 Henry F. Vaughan, Dr. P.H.
 Joseph S. Wall, M.D.
 Charles O. Williams
 William Wirt, Ph.D.

1929

James Ford Bell
 Harvey J. Burkhart, M.D.
 Merrill E. Champion, M.D.
 Taliaferro Clark, M.D.
 John H. Finley
 John A. Foote, M.D.
 Elizabeth Fox, R.N.
 * Samuel McC. Hamill, M.D.
 Gertrude Lane
 * Sara B. Place, R.N.
 * Edgar Rickard
 Fred Stricker, M.D.
 Allen Wardwell
 Herbert B. Wilcox, M.D.
 * Linsly R. Williams, M.D.
 William C. Woodward, M.D.

* Member of the Executive Committee.

STAFF

COURTENAY DINWIDDIE, *General Executive*
 ELLA PHILLIPS CRANDALL, *Associate General Executive*
 SAMUEL MCC. HAMILL, M.D., *Ad Interim Director Medical Service*
 S. J. CRUMBINE, M.D., *Director Public Health Relations*
 EMMA DOLFINGER, *Director Health Education Division*
 GEORGE T. PALMER, Dr. P.H., *Director of Research*
 ARTHUR TOMALIN, *Director of Publications*
 NATIONAL ORGANIZATION FOR PUBLIC HEALTH
 NURSING, *Directing Nursing Service with the A.C.H.A. in the Field of Child Health*
 ADA DE ACOSTA ROOT, *Director of Promotion*
 CORNELIA LYNE, *Administrative Assistant*
 CHARLES H. FRAZER, *Office Manager*

RESOLUTIONS

The following Resolutions were presented and approved:

Resolution I

WHEREAS, Accidents from concentrated lye and other dangerous caustic substances frequently cause serious injuries and sometimes death, especially among children, and

WHEREAS, The frequency of such accidents might be diminished by poison labels, and their severity mitigated by instructions as to emergency treatment, conspicuously placed on the labels of the containers in which such poisonous substances are distributed for household use, be it

RESOLVED, That it is the sense of the American Child Health Association that such federal and state laws should be enacted as may be necessary to require household packages of concentrated lye and other dangerous caustic substances to bear poison labels and directions for emergency treatment; and

RESOLVED FURTHER, That copies of this resolution be sent to the Chairman of the Committee on Interstate Commerce of the United States Senate and the Chairman of the Committee on Interstate and Foreign Commerce of the House of Representatives, and to each of the State Legislatures meeting during the calendar year of 1925.

Resolution II

WHEREAS, The National Health Council has invited the American Child Health Association to participate in a joint convention of its member organizations to be held in May, 1926, and

WHEREAS, It is the hope that this convention may be international in character, and

WHEREAS, The holding of a meeting of the American Child Health Association with a professional program in October, 1925, would bring the two meetings within eight months of one another,

THEREFORE, BE IT RESOLVED, That the American Child Health Association approve of the plan of a joint convention of the National Health Council to be held in May, 1926, and authorize the Board of Directors to take such steps as are necessary for participation in this Convention by the American Child Health Association, and

BE IT FURTHER RESOLVED, That the elimination of the Convention features of the Annual Meeting of the American Child Health Association in 1925 be left to the discretion of the Board of Directors.

Resolution III

RESOLVED, That the Officers, Directors and Members of the American Child Health Association desire to express their lasting appreciation to the citizens of Kansas City, Missouri, for their hospitality and for the many courtesies extended by individuals and organized groups.

Particular thanks are due the local committee on arrangements and to the organization which its members represent. Special acknowledgment is also made of the service of the local press in making available to the general public some of the principles of child hygiene as set forth by the various speakers at our meeting.

Kansas City Local Committee

Frank C. Neff, M.D., Chairman Local Committee

John Aull, M.D., Harry C. Berger, M.D., O. F. Bradford, M.D., Joseph
Cowherd, M.D., Hugh L. Dwyer, M.D., O. J. Eldridge, M.D., Ed-
win H. Schorer, M.D., Damon Walthall, M.D.....

Members of the Kansas City Pediatric Society

Scott P. Child, M.D.....President, Jackson County Medical Society
Lewis G. Allen, M.D.....President, Wyandotte County Medical Society
E. H. Skinner, M.D.....Kansas City Clinical Society
George Clark Mosher, M.D.....Chairman, Certified Milk Commission
J. R. McVey, M.D.....Member Missouri State Board of Health
J. M. Frankenburger, M.D.....Superintendent, General Hospital
Judge E. E. Porterfield.....Juvenile Court
William Volker.....Member of the Kansas City School Board
L. A. Halbert.....Secretary, Council Social Agencies
H. W. Whitson.....Superintendent, Provident Association
Fred Bannister.....President, Chamber of Commerce
Nellie Flannigan.....Social Workers Conference
Mrs. Sam Sebree.....President Junior League
Mrs. Henry Cohen.....Executive Director, Jewish Education Institute
Mrs. E. R. Weeks.....Chairman, Local Children's Bureau
Mrs. F. C. Edwards.....Head Resident, Swope Settlement
Mary G. Burman.....Superintendent Mercy Hospital
Rev. J. B. Bisceglia.....Italian Settlement House
Jesse M. Sodermann.....Superintendent Gillis Orphans' Home
Mrs. Fred Lamb.....President, Institutional Church
Florence Russell.....President Minute Circle Friendly House
Phyllis Dacey.....Visiting Nurse Association
Sister Andrea.....Treasurer, Kansas City Orphan Boys' Home
Nina Remfry.....President, Richard Cabot Club
Mrs. W. A. Cochel...President, Grace and Holy Trinity Well Children's Station
Mrs. Frankie Hinde.....President, Whatsoever Circle
Mrs. Paul Oope.....President, Parent-Teacher Association
Mrs. Herbert V. Jones.....President, Consumers League
Mary Burke.....President, Amberg Club
Mrs. John Townley.....President, South Side Children's Relief
Mrs. Benjamin L. Hart.....President, Athensum
Raymond Watson.....President, Kiwanis Club

INDEX

- Aberdeen, S. D. Public Health Center of Brown County, 375.
- Adair, Fred L., M.D., and O'Brien, William A., M.D. Causes and prevention of antenatal, intranatal, postnatal, and neonatal deaths, 253-62.
- Adolescence, Educational phases of early. Wilford M. Aikin, 126-35.
- Adolescence, Physical aspects of. Borden S. Veeder, M.D., 111-16.
- Affiliated Societies, Reports, 277-390.
- Aikin, Wilford M. Educational phases of early adolescence, 126-35.
- Alameda County Tuberculosis Association, California, 279.
- Albany, N. Y.:
New York State Department of Health, Division of Maternity, Infancy and Child Hygiene, 331.
State Board of Charities, 332.
- Alumnae Assoc. of the Connecticut Training School for Nurses, Inc., New Haven, Conn., 288.
- American Child Health Association:
Annual Meeting:
Presidential message. Herbert Hoover, 3.
Opening address. Thomas D. Wood, M.D., 5-6.
Reports:
Executive committee, 7-8.
Financial report, 8.
General executive, 9-34.
Second annual meeting:
Business Sessions, 393-94.
Resolutions, 396.
Sessions:
Discussion of some special aspects of child health work, 169-94.
Essentials of community organization for child health work, 195-249.
General session, 1-33.
Joint session on pediatrics and obstetrics of A. C. H. A. with Kansas City Clinical Society, 251-75.
Problems of late childhood and early adolescence, 109-135.
Public health program, 95-108.
Training leaders for child health work, 37-54.
Training leaders for child health work. Group discussion, 55-84.
Kansas City local committee, 397.
Demonstrations, 25-30.
Objectives, 13-25.
Officers and directors, 395.
Program for 1925, 30-32.
- American Dental Association, Chicago, Ill., 295.
- American Nurses' Association, New York City, 335.
- American Red Cross. Greater Berwick Chapter, Nursing Service, Berwick, Pa., 361.
- America's greatest asset—her children. S. J. Crumline, M.D., 165-67.
- Argonne Association of America, New York City, 335.
- Associated Charities, Cleveland, Ohio, 351.
- Athens (Ga.) Demonstration, 29-30.
- Atlanta, Ga., State Association of Graduate Nurses, 294.
- Atlantic City, N. J.:
Child Federation of, 329.
Day Nursery, 328.
- Augusta, Ga.:
Children's Hospital Association, 294.
- Augusta, Me.:
Maine Public Health Association, 305.
- Austin, Tex.:
Bureau of Child Hygiene of the State Board of Health, 375.
Division of Nutrition and Health Education, Bureau of Extension, University of Texas, 376.
- Babies and younger children, Rural health supervision of. Florence L. McKay, M.D., 221-25.
- Babies and younger children, Work for. Mary Margaret Roche, R.N., 206-9.
Discussion:
Falfrey, 209.
Roche, Mary Margaret, R.N., 209.
Sinclair, John F., M.D., 209.
- Babies' Dispensary and Hospital of Cleveland, Ohio, 348.
- Babies' Dispensary Guild, The, Hamilton, Ontario, Canada, 385.
- Babies' Hospital:
City of New York, 335.
Newark, N. J., 330.
Philadelphia, 362.
- Baby and Child Hygiene Associations:
Babies' Milk Fund Association:
Baltimore, Md., 306.
Cincinnati, Ohio, 347.
Evansville, Ind., 299.
Detroit, Mich., 316.
- Baby Hygiene Committee, Bay Branch of the American Association of University Women, San Francisco, Calif., 280.
- Baby Welfare Committee, Utica, N. Y., 347.
- Child Welfare:
Association, New Orleans, La., 304.
Society, Freeport, Ill., 297.
Station, Department of the Elkhart Chapter, League of Women Voters, Ind., 298.
- City of Bethlehem, Baby Health Station, Pa., 361.
- Colorado Child Welfare Bureau, Denver, Col., 283.
- Diet Kitchen of the Oranges, N. J., 330.
- Holyoke Child Welfare Commission, Mass., 313.
- Infant Welfare Society:
Chicago, Ill., 297.
Minneapolis, Minn., 320.
- Portland Baby Hygiene and Child Welfare Association, Me., 306.
- Providence Child Welfare Committee, R. I., 372.
- St. Paul Baby Welfare Association, Minn., 322.
- Scottish Rite Infant Welfare Department, Duluth, Minn., 318.

- Baby and Child Hygiene Associations, *see* also Clinics, Health Centers, and Stations, and Nursing.
- Baby Hygiene Committee, San Francisco, Bay Branch of the American Association of University Women, 280.
- Baby Welfare Comm. of Utica, N. Y., 347.
- Baltimore, Md.:
Babies' Milk Fund Association, 306.
Florence Crittenton Mission, Inc., 306.
Health Department, Bureau of Child Welfare, 307.
Henry Watson Children's Aid Soc., 307.
Jewish Children's Bureau, 308.
- Bears, Elmira W., R.N. Organization of school nursing, 238-40.
Discussion, 245-46.
- Berkeley, Calif.:
Health Center, 278.
Department of Hygiene, University of California, 278.
- Berkshire Industrial Farm, Canaan, N. Y., 334.
- Berwick, Pa. American Red Cross, Greater Berwick Chapter, Nursing Service, 361.
- Bethlehem, Pa. Baby Health Station, 361.
- Blackmar, F. W., Ph.D. Discussion, 72-73.
- Boston, Mass.:
Floating Hospital, On-Shore Department, 308.
School of Physical Education, 309.
Community Health Association, 309.
Department of Public Health, The Commonwealth of Massachusetts, 310.
Forsyth Dental Infirmary, 311.
Massachusetts Parent-Teacher Association, 311.
Massachusetts Tuberculosis League, 311.
New England Dairy and Food Council, 312.
- Bradley, Charles W. Discussion, 131-33.
- Bridgeport, Conn.:
City Department of Health, Bureau of Child Hygiene, 285.
Department of Public Charities, 285.
The Visiting Nurse Association of Bridgeport, 286.
- Brooklyn, N. Y.:
Maternity Center Association of the Borough of, 332.
Visiting Nurse Association, 338.
- Brown, Walter H., M.D. What are the fundamentals in community protection of child health? 142-48.
Discussion, 81, 148.
- Bryan, Mrs. Edith. Discussion, 64.
- Buffalo, N. Y. District Nursing Association, 333.
- Bureau of Child Hygiene and Public Health Nursing, State Board of Health, Jackson, Miss., 322.
- Bureau of Child Hygiene:
State Board of Health, Austin, Tex., 375.
California State Board of Health, San Francisco, 281.
Division of Health, Cleveland, Ohio, 349.
State Board of Health, Portland, Ore., 359.
- Bureau of Child Welfare and Public Health Nursing, State Board of Health, Jacksonville, Fla., 294.
- Bureau of Educational Experiments, New York City, 336.
- California Dairy Council, San Francisco, 281.
- Cambridge, Mass.:
Health education conference, 183-87.
Ward IV Infant Welfare, 312.
- Canaan, N. Y. Berkshire Industrial Farm, 334.
- Canada:
Babies' Dispensary Guild, Hamilton, Ont., 385.
Child Welfare Association, Montreal, Que., 386.
Child Welfare Division, Department of Health, Fredericton, N. B., 384.
Department of Public Health:
Edmonton, Alta., 383.
Child Hygiene Section, Toronto, Ont., 385.
Mass.-Halifax Health Commission, Halifax, N. S., 384.
Public Health Nursing Service, Victoria, B. C., 383.
- Champion, Merrill E., M.D. Discussion, 243-44, 247-49.
- Charities, Associations and Aid Societies:
Association for Improving the Condition of the Poor, New York City, 342.
Children's Aid Society:
New Bedford, Mass., 314.
St. Louis, Mo., 325.
- Associated Charities, Cleveland, Ohio, 351.
- Crippled Children's Aid Society, New Haven, Conn., 288.
- Public Charities Department, Bridgeport, Conn., 285.
- Henry Watson Children's Aid Society, Baltimore, Md., 307.
- Public Charities Association of Pennsylvania, Philadelphia, 366.
- State Board of Charities, Albany, N. Y., 352.
- State Charities Aid Association, New York City, 344.
- Chicago, Ill.:
American Dental Association, 295.
Elizabeth McCormick Memorial Fund, 296.
Infant Welfare Society, 297.
Lying-In Hospital and Dispensary, 295.
Woman's Club, 296.
- Child Federation of Atlantic City, N. J., 329.
- Child health, Internationalization of. Sally Lucas Jean, 102-108.
- Child health, What are the fundamentals in community protection of. Walter H. Brown, M.D., 142-48.
Discussion:
French, William J., M.D., 148.
Brown, Walter H., M.D., 148.
- Child Health Demonstrations, *see* Demonstrations.
- Child Health Program:
Essentials of preparation for community organizers. E. L. Morgan, 48-54.
Discussion:
Smith, Richard M., M.D., 53-54.
Wood, Thomas D., M.D., 54.
- Essentials of preparation for health educators in a community child health program. C. E. Turner, 41-44.
- Essentials of preparation for physicians in a community. Clifford G. Grulee, M.D., 38-40.
- Essentials of preparation for public health nurses in relation to. Sophie C. Nelson, R.N., 45-47.
- Joint responsibility of public and private agencies and obligations of community in observation of child health program. Annie S. Veech, M.D., 162-64.
- Child Health Promotion, Report, 190-94.
- Child Health Work:
Discussion of some special aspects of. Session, 169-94.
Essentials of community organization for. Session, 137-67.

- Child Health Work: (*Continued*)
 Essentials of community organization for. Sessions, 195-249.
 Training leaders for. Group discussion, 55-94.
 Training leaders for. Session, 35-94.
- Child Hygiene Division State Health and Welfare Commission, Dover, Del., 292.
- Child Welfare and Nutrition Clinic, Division of Home Economics, Kansas State Agricultural College, Manhattan, Kan., 303.
- Child Welfare:
 Association, East Cleveland, Ohio, 356.
 Association, Montreal, Canada, 386.
 Association, New Orleans, La., 304.
 Division of State Board of Health, Reno, Nev., 327.
 Division of the Department of Health, Fredericton, N. B., Canada, 384.
 Division, Rhode Island State Board of Health, Providence, 372.
 Society, Freeport, Ill., 297.
 Station, Child Welfare Department of the Elkhart Chapter, Indiana League of Women Voters, 298.
- Childhood and early adolescence, Problems of. Session, 109-35.
 Discussion:
 Bradley, Charles W., 181-33.
 Curtis, Henry S., Ph.D., 133-34.
 Wilson, 135.
- Childhood and early adolescence, Problems of.—mental aspects. Sidney I. Schwab, M.D., 117-25.
- Children, Preschool, *see* Preschool children.
- Children's Aid Society Clinic, Cleveland, Ohio, 349.
- Children's Bureau:
 Cleveland, Ohio, 350.
 Kansas City, Mo., 323.
- Children's Dispensary and Hospital Association, South Bend, Ind., 301.
- Children's Fresh Air Camp and Hospital of Cleveland, Ohio, 350.
- Children's Hospital:
 Association, Augusta, Ga., 294.
 Department for the Prevention of Disease, Philadelphia, Pa., 363.
 Michigan, 316.
- Children's Welfare Federation, New York City, 336.
- China. Council on Health Education, Shanghai, 389.
- Cincinnati, Ohio:
 Anti-Tuberculosis League, 348.
 Babies' Milk Fund Association, 347.
 Public Health Federation, 348.
- City Department of Health, Bureau of Child Hygiene, Bridgeport, Conn., 285.
- City Work:
 Training leaders for child health work. Nurses' section. Phyllis M. Dacey, R.N., 61-65.
 Training leaders for child health work in the city. Community organizers' section. William J. French, M.D., 74-81.
- Discussion:
 Ewing, William C., 78-79.
 Sinclair, John S., M.D., 79.
 Schweitzer, Ada E., M.D., 79-80.
 Keeley, 80.
 Hamblin, H. E., M.D., 80.
 Brown, Walter H., M.D., 81.
- Clark, Taliaferro, M.D., presiding. Essentials of community organization for child health work. Joint session, 247-49.
 Discussion, 243.
- Cleveland, Ohio:
 Associated Charities, 351.
 Babies' Dispensary and Hospital, 348.
 Bureau of Child Hygiene, Division of Health, 349.
 Children's Aid Society Clinic, 349.
 Children's Bureau, 350.
 Children's Fresh Air Camp and Hospital, 350.
 Council Educational Alliance, 353.
 Cuyahoga County Board of Health, 353.
 Day Nursery and Free Kindergarten Association, 353.
 Humane Society, 351.
 Jewish Home for Friendless Children, 354.
 Merrick House Day Nursery and Settlements, 354.
 Nutrition Clinics, 352.
 Protestant Orphan Asylum, 352.
 Public Health Nursing District, Western Reserve University, 354.
 Red Cross Teaching Center, 355.
 Salvation Army Rescue Maternity Hospital and Nursery, 355.
 Society of the Home of the Holy Family, 355.
 Visiting Nurse Association, 356.
- Clinics, Health Centers, and Stations:
 Berkeley Health Center, Berkeley, Calif., 278.
 Child Welfare and Nutrition Economics, Kansas State Agricultural College, Manhattan, Kan., 303.
 Children's Aid Society Clinic, Cleveland, Ohio, 349.
 Children's Health Station, Hartford, Conn., 286.
 Cleveland Nutrition Clinics, Cleveland, Ohio, 352.
 Community Health Center, Philadelphia, Pa., 363.
 East Harlem Nursing and Health Demonstration, New York City, 337.
 Judson Health Center, New York City, 339.
 Newburyport Health Center, Newburyport, Mass., 315.
 Public Health Center of Alameda County, Calif., 280.
 Public Health Center of Brown County, Aberdeen, S. D., 375.
 Starr Center Association, Philadelphia, Pa., 367.
 Ward IV Infant Welfare Committee of Cambridge, Mass., 312.
 Yale Psycho-Clinic, New Haven, Conn., 290.
- Clinics, Health Centers, and Stations, *see* also Baby and Child Hygiene Associations and Nursing.
- Clinics. Work for babies and younger children, 206-9.
- Colorado Child Welfare Bureau, Denver, 283.
- Colorado Springs, Colo. Day Nursery, 283.
- Colorado Tuberculosis Association, Denver, 284.
- Columbus, Ohio, State Association of Graduate Nurses, 356.
- Community child health work, Relation of the press to, 158-61.
 Discussion:
 Jean, Sally Lucas, 161.
 Community Health Association, Boston, Mass., 309.
 Community Health Center, Philadelphia, Pa., 363.
 Community Organization for Child Health Work, Essentials of, (continued) Session, 137-67, 229-49.

- Community organizers, Essentials of preparation for. El. L. Morgan, 48-54.
- Community organizers' section. Training leaders for child health work. Group discussion, 67-81.
- Community protection of child health, What are the fundamentals in. W. H. Brown, M.D., 142-48.
- Connecticut:
Organization for Public Health Nursing, Norwich, 291.
State Department of Health, Bureau of Child Hygiene, Hartford, Conn., 287.
- Council Educational Alliance, Cleveland, Ohio, 853.
- Council on Health Education, Shanghai, China, 389.
- County Service, Pittsburgh, Pa., 369.
- Crandall, Ella Phillips:
May Day, introductory remarks, 189-90.
Report of Aida de Acosta Root, read by E. F. Crandall, 190-94.
- Crippled Children's Aid Society, New Haven, Conn., 288.
- Crumbine, Samuel J., M.D.
America's greatest asset—her children, 165-67.
Practical application of the findings of the survey of eighty-six cities, 179-82.
- Curtis, Henry S., Ph.D. Discussion, 133-34.
- Cuyahoga County Board of Health, Cleveland, Ohio, 353.
- Czechoslovakia Red Cross, Prague, 388.
- Dacey, Phyllis M., R.N. Training leaders for child welfare work in the city, 61-65.
- Day Nurseries:
Atlantic City, N. J., 328.
Colorado Springs, Colo., 283.
Long Beach, Calif., 278.
Merrick House Day Nursery and Settlement, Cleveland, Ohio, 353.
National Federation of Day Nurseries, New York City, 341.
Philadelphia, Pa., 363.
Woods Run Settlement Day Nursery, Pittsburgh, Pa., 369.
- Demonstrations, 25-30.
- Dental Associations and Clinics:
American Dental Association, Chicago, Ill., 295.
Forsyth Dental Infirmary, Boston, Mass., 311.
Toledo, Ohio, Dental Dispensary Association, 357.
- Denver, Colo.:
Colorado Child Welfare Bureau, 283.
Colorado Tuberculosis Association, 284.
Tuberculosis Society, 284.
Visiting Nurse Association, 285.
- Department:
Hygiene, University of California, Berkeley, 278.
Public Charities, Bridgeport, Conn., 285.
Public Health, Commonwealth of Massachusetts, Boston, Mass., 310.
Public Health, Child Hygiene Section, Toronto, Ont., Canada, 385.
- Des Moines, Ia. Iowa Tuberculosis Association, 301.
- Detroit, Mich.:
Babies' Milk Fund, 316.
Children's Hospital of Michigan, 316.
Merrill-Palmer School, 317.
- Diet Kitchen of the Oranges, N. J., 330.
- Dinwiddie, Courtenay. Progress in child health—second annual report, 8-33.
- District Nurse Association, Middletown, Conn., 288.
- District Nursing Association, Buffalo, N. Y., 333.
- Division of Child Hygiene:
City Board of Health, Indianapolis, Ind., 299.
Department of Health and Welfare, Lincoln, Neb., 326.
State Board of Health, Minneapolis, Minn., 319.
State Department of Health, Seattle, Wash., 378.
- Division of Child Welfare, Health Department, Milwaukee, Wisc., 378.
- Division of Nutrition and Health Education, Bureau of Extension, University of Texas, 376.
- Doctor of the future. George E. Vincent, Ph.D., 97-101.
- Dolinger, Emma. Presiding. Teachers' section. Group discussion. Training leaders for child health work, 83-94.
Discussion, 88-89, 93-94.
- Dover, Del. Child Hygiene Division, State Health and Welfare Commission, 292.
- Duluth, Minn. Scottish Rite Infant Welfare Department, 318.
- East Cleveland, Ohio. Child Welfare Association, 356.
- East Harlem Nursing and Health Demonstration, New York City, 337.
- Eaton, Ohio. Preble County Board of Health, 357.
- Edmonton, Alta., Canada. Department of Public Health, 383.
- Eduardo Liceaga Hygiene Institute, State Department of Public Health, Mexico, 387.
- Education Department of the Division of Hygiene, St. Paul, Minn., 321.
- Educational phases of early adolescence. Wilford M. Aikin, 126-35.
Discussion:
Bradley, Charles W., 131-33.
Curtis, Henry S., Ph.D., 133-34.
Wilson, 135.
- Eighty-six cities—survey, 9-15, 173-78, 179-82.
- Elizabeth McCormick Memorial Fund, Chicago, Ill., 296.
- Elkhart, Ind.:
Child Welfare Station, Child Welfare Department of the Elkhart Chapter, Indiana League of Women Voters, 298.
Red Cross Public Health Nursing Bureau, 298.
- Emma Moss Booth Memorial Hospital and Training School for Nurses, Greenville, S. C., 374.
- Erie, Pa. Anti-Tuberculosis Society, 362.
- Evansville, Ind. Babies' Milk Fund Association, 299.
- Ewing, William C. Discussion, 78-79, 194, 214-15, 248, 249.
- Falfrey, Miss. Discussion, 209.
- Fall River, Mass. Maternal and Child Welfare Commission, 312.
- Falmouth, Mass. Nursing Association, 313.
- Family Welfare Society, Indianapolis, Ind., 299.
- Far West, Conditions in. Elnora Thomson, R.N., 188-89.
- Far Western Demonstration, *see* Marion County (Ore.) Demonstration.
- Fargo (N. D.) Demonstration, 28-29.
- Faverley, Helen. Discussion, 64-65.
- Federation for Child Study, Summer Play Schools, New York City, 337.

- Fitchburg, Mass. Visiting Nurse Association, 313.
- Flint, Mich. Department of Health, 317.
- Florence, Crittenton Mission, Baltimore, Md., 306.
- Forsyth Dental Infirmary, Boston, 311.
- Frederickton, N. B., Canada. Child Welfare Division of the Department of Health, 384.
- Freeport, Ill. Child Welfare Society, 297.
- French, William J., M.D. Training leaders for child health work in the city, 74-81.
- Discussion, 148.
- Greenville, S. C. Emma Moss Booth Memorial Hospital and Training School for Nurses, 374.
- Grulee, Clifford G., M.D. Essentials of preparations for physicians in a community child health program, 38-40.
- Halifax, N. S., Canada. Massachusetts-Halifax Health Commission, 384.
- Hamblin, H. E., M.D. Discussion, 80.
- Hamilton, Ont. Canada. Babies' Dispensary Guild, 385.
- Hartford, Conn.:
Children's City Health Stations, 286.
Conn. State Department of Health, Bureau of Child Hygiene, 287.
- Hawaiian Islands. Palama Settlement, District Nursing Department, Honolulu, 380.
- Health Department:
Bureau of Child Welfare, Baltimore, Md., 307.
- Child Hygiene Service, Washington, D. C., 293.
- Health Departments:
1. State and Provincial:
Canada, Edmonton, Alta., 383.
Mass., Boston, Commonwealth of, 310.
P. I., Manila, Office of the Public Welfare Commissioner, 381.
 2. State and Provincial Divisions of Child Hygiene, Maternity, or Child Welfare:
California, San Francisco, 281.
Canada, Frederickton, N. B., 384; Toronto, Ont., 385.
Connecticut, Hartford, 287.
Delaware, Dover, 292.
Florida, Jacksonville, 294.
Mexico, Eduardo Liceaga Hygiene Inst., 387.
Mexico, Manuel Dominguez Child Welfare Station, 387.
Michigan, Lansing, 318.
Minnesota, Minneapolis, 319.
Mississippi, Jackson, 322.
Nebraska, Lincoln, 326.
Nevada, Reno, 327.
New York, Albany, 331.
Oregon, Portland, 359.
Rhode Island, Providence, 372.
Tennessee, Nashville, 375.
Virginia, Richmond, 377.
Washington, Seattle, 378.
 3. City:
Baltimore, Md., 307.
Bridgeport, Conn., 285.
Flint, Mich., 317.
Indianapolis, Ind., 299.
Manchester, N. H., 328.
Racine, Wisc., 379.
 4. City Divisions of Child Hygiene, Maternity or Child Welfare:
Milwaukee, Wisc., 378.
Providence, R. I., 372.
Washington, D. C., 293.
- Health Departments: (*Continued*)
5. County:
Cuyahoga, Cleveland, Ohio, 353.
Preble, Eaton, Ohio, 357.
Tulsa, Okla., 359.
- Health Education:
Bureau of Educational Experiments, New York City, 336.
Child Health Society (formerly The Child Federation), Philadelphia, Pa., 364.
Council Educational Alliance, Cleveland, Ohio, 353.
Council on Health Education, Shanghai, China, 389.
Federation for Child Study, Summer Play Schools, New York City, 337.
Hygiene Department of University of California, Berkeley, Calif., 278.
Hygiene Department, Cornell University, Ithaca, N. Y., 334.
Mothers' Educational Center, Los Angeles, Calif., 279.
Nutrition and Health Education Division, Bureau of Extension, University of Texas, Austin, Tex., 376.
Red Cross Teaching Center, Cleveland, Ohio, 355.
School of Physical Education, Boston, Mass., 309.
- Health education conference at the Massachusetts Institute of Technology. C. E. Turner, 183-87.
- Health education for teachers. Elma Rood, R.N., 90-94.
- Health educators in a community child health program, Essentials of preparation for. C. E. Turner, 41-44.
- Health program, Will communities pay for an adequate. Bleecker Marquette, 140-56.
- Discussion:
Mustard, H. S., M.D., 157.
- Health supervision and education, Contributions of the home demonstration agent to. Louise Stanley, Ph.D., 216-20.
- Health supervision and education for mothers, babies and younger children, 195-228.
- Health teaching through nature study. Mildred Sykes, 85-88.
- Discussion:
Dolinger, Emma, 88-89.
Murphy, Mary E., 89.
Richardson, Anna, 89.
Phillips, 89.
- Health work in the schools, 229-46.
- Henry Street Visiting Nurse Service of New York City, 338.
- Henry Watson Children's Aid Society, Baltimore, Md., 307.
- Hixson, R. H. Relation of the press to community child health work, 158-61.
- Holyoke, Mass. Child Welfare Commission, 313.
- Home demonstration agent. Contribution of. Louise Stanley, Ph.D., 216-20.
- Home economics department. Relation to class-room teacher. Rose Shonka, 241-43.
- Discussion:
Rood, Elma, R.N., 243, 244.
Wood, Thomas D., M.D., 243, 244-45.
Clark, Tallafarro, M.D., 243.
Champion, Merrill E., M.D., 243-44.
Bears, Elmira W., R.N., 245, 246.
Shonka, Rose, 245.
- Honolulu, Hawaii. Palama Settlement, District Nursing Department, 380.
- Hoover, Herbert. Presidential message, 3.

- Hospital Social Service :
 New York City, Nursery and Child's Department, 344.
 Association of New York City, 338.
 Philadelphia, Pa., Preston Retreat, 365.
 St. Christopher's Hospital for Children, 366.
- Hospitals :
 Augusta, Ga., Children's, 294.
 Boston, Mass., Floating, On-Shore Department, 308.
 Chicago, Ill., Lying-In, 295.
 Cleveland, Ohio, Babies' Dispensary and, 348.
 Children's Fresh Air Camp and, 350.
 Salvation Army Rescue Maternity and Nursery, 355.
 Detroit, Mich., Children's, 316.
 Greenville, S. C., Emma Moss Booth Memorial, 374.
 Milwaukee, Wisc., Infants', 379.
 Newark, N. J., Babies', 380.
 New York City, Babies', 385.
 Philadelphia, Pa., Babies', 362.
 Children's, Department for the Prevention of Disease, 363.
 Rochester, N. Y., General, and Dispensary, 346.
 St. Louis, Mo., Maternity, 325.
 South Bend, Ind., Children's Dispensary and, 301.
 Hudson County Tuberculosis League, Jersey City, N. J., 329.
 Humane Society, Cleveland, Ohio, 351.
 Hunner, Guy L., M.D. Recent clinical studies in urology, 270-75.
 Hygiene Department, Cornell University, Ithaca, N. Y., 334.
- Indianapolis, Ind. :
 Division of Child Hygiene, City Board of Health, 299.
 Family Welfare Society, 299.
 Public Health Nursing Association, 300.
- Infant mortality. Causes and prevention of antenatal, intranatal, postnatal, and neonatal deaths. Fred L. Adair, M.D., and William A. O'Brien, M.D., 253-62.
- Infant Welfare :
 Society, Chicago, Ill., 297.
 Society, Minneapolis, Minn., 320.
- Infants, Clinical aspects of tuberculosis in. Richard M. Smith, M.D., 263-69.
- Instructive Nursing Association, New Bedford, Mass., 314.
- Internationalization of child health and its significance. Sally Lucas Jean, 102-108.
- Iowa Child Welfare Research Station, Iowa City, 302.
- Iowa City :
 Child Welfare Research Station, 302.
 School of Public Health Nursing, 302.
- Iowa Tuberculosis Association, Des Moines, 301.
- Ithaca, N. Y. Hygiene Department, Cornell University, 334.
- Jackson, Miss. Bureau of Child Hygiene and Public Health Nursing, State Board of Health, 322.
- Jacksonville, Fla. Bureau of Child Welfare and Public Health Nursing, State Board of Health, 294.
- Jamestown, N. Y. Visiting Nurse Association, 334.
- Jean, Sally Lucas. Internationalization of child health and its significance, 102-108.
 Discussion, 161.
- Jersey City, N. J. Hudson County Tuberculosis League, 329.
- Jewish Board of Guardians, New York City, 338.
- Jewish Children's Bureau, Baltimore, Md., 308.
- Jewish Home for Friendless Children, Cleveland, Ohio, 354.
- Joseph Lawrence Training School, Lawrence and Memorial Associated Hospitals, New London, Conn., 291.
- Judson Health Center, New York City, 339.
- Kansas City, Mo. :
 Children's Bureau, 323.
 Minute Circle, Friendly House, 323.
 Thomas H. Swope Settlement, 324.
 Visiting Nurse Association, 324.
 Annual fall clinical conference and medical association of the Southwest. Joint meeting, 95-108.
 Clinical Society. Joint session with A. C. H. A. on pediatrics and obstetrics, 251-75.
- Keeley, Miss. Discussion, 80.
- Koenig, Margaret, M.D. Discussion, 225.
- Lansing, Mich. Michigan Department of Health, Bureau of Child Hygiene and Public Health Nursing, 318.
- Lincoln, Neb. Division of Child Hygiene, Department of Health and Welfare, 326.
- Lindley, E. H., presiding. Public health program. Session, 95-108.
- Long Beach, Calif. Long Beach Day Nursery, 278.
- Los Angeles, Calif. Mothers' Educational Center, 279.
- Louisville, Ky. Public Health Nursing Association, 304.
- Lying-In Hospital and Dispensary, Chicago, Ill., Mothers' Aid Society, 295.
- Maine Public Health Association, Augusta, 305.
- Manchester, N. H. Health Department, 328.
- Manhattan, Kan. Child Welfare and Nutrition Clinic, Division of Home Economics, Kansas State Agricultural College, 303.
- Manila, P. I. :
 Office of the Public Welfare Commissioner, 381.
 Philippines Chapter of the American Red Cross, 382.
- Mansfield (Ohio) Demonstration, 26-27.
- Manuel Dominguez Child Welfare Station, State Department of Health, Mexico, 387.
- Marion County (Ore.) Demonstration, 30.
- McKay, Florence L., M.D. Rural health supervision of babies and younger children, 221-25.
- Marquette, Bleecker. Will communities pay for an adequate health program, 149-57.
- Massachusetts-Halifax Health Commission, 384.
- Massachusetts :
 Parent-Teacher Association, 311.
 Tuberculosis League, 311.
- Maternal and Child Welfare Commission, Fall River, Mass., 312.
- Maternity Center Association :
 Borough of Brooklyn, 322.
 New York City, 339.
- Maternity work. George Clark Mosher, M.D., 197-205.

- May Day for child health. Aida de Acosta Root, 190-94.
- Medical Department of the Polish-American Children's Relief Committee, Warsaw, Poland, 389.
- Mental aspects—Problems of childhood and early adolescence. Sidney I. Schwab, M.D., 117-25.
- Merrick House Day Nursery and Settlement, Cleveland, Ohio, 354.
- Merrill-Palmer Motherhood and Home Training School, Detroit, Mich., 317.
- Mexico:
- State Department of Health, The Eduardo Liceaga Hygiene Institute, 387.
 - State Department of Health, Manuel Dominguez Child Welfare Station, 387.
- Michigan Department of Health, Bureau of Child Hygiene and Public Health Nursing, Lansing, Mich., 318.
- Middletown, Conn. District Nurse Association, 288.
- Miller, Mrs. Walter McNab, Presiding. Discussion of some special aspects of child health work, 169-94.
- Milwaukee:
- Division of Child Welfare, Health Department, 378.
 - Milwaukee Infants' Hospital, 379.
- Minneapolis, Minn.:
- Division of Child Hygiene, State Board of Health, 319.
 - Infant Welfare Society, 320.
 - Visiting Nurse Association, 321.
- Minnesota, University of. Rural public health nursing, 57-60.
- Minute Circle, Friendly House, Kansas City, Mo., 323.
- Missouri State Nurses' Association, St. Louis, 324.
- Mitchell, Harold H., M.D. Organization of school medical inspection, 233-37.
- Morgan, E. L. Essentials of preparation for community organizers, 48-54.
- Morgan, E. L., presiding. Community organizers' section. Group discussion. Training leaders for child health work, 67-81.
- Discussion, 79-80.
- Mosher, George Clark, M.D. Maternity work, 197-205.
- Mothers' Educational Center, Los Angeles, Calif., 279.
- Montreal, Que., Canada. Child Welfare Association of Montreal, 386.
- Mulberry Community House, New York City, 340.
- Mulcahy, Charlotte. Discussion, 64.
- Municipal Visiting Nurses, St. Louis, Mo., 324.
- Murphy, Mary E. Discussion, 89.
- Mustard, H. S., M.D. Discussion, 157.
- Nashville, Tenn. State Department of Public Health, Division of Maternal and Infant Hygiene, 375.
- National Child Labor Committee, New York City, 340.
- National Child Welfare Association, New York City, 341.
- National Congress of Parents and Teachers, Washington, D. C., 293.
- National Federation of Day Nurseries, New York City, 341.
- National League of Nursing Education, New York City, 341.
- National Tuberculosis Association, New York City, 342.
- Nature study, Health teaching through. Mildred Sykes, 85-88.
- Neff, Frank C., M.D. Presiding. Problems of late childhood and early adolescence. Session, 109-35.
- Nelson, Sophie C., R.N. Essentials of preparation for public health nurses in relation to the child health program, 45-47.
- Nelson, Sophie, R.N. Presiding. Nurses' section. Group discussion. Training leaders for child health work, 55-65.
- Newark, N. J. Babies' Hospital, 330.
- New Bedford, Mass.:
- Instructive Nursing Association, 314.
 - Children's Aid Society, 314.
- Newburgh, N. Y. Child Welfare Committee, 345.
- Newburyport, Mass. Health Center, 315.
- New England Dairy and Food Council, Boston, Mass., 312.
- New Haven, Conn.:
- Alumnae Association of the Conn. Training School for Nurses, 288.
 - Crippled Children's Aid Society, 288.
 - Visiting Nurse Association, 289.
 - Yale Psycho-Clinic, 290.
- New London, Conn. Joseph Lawrence Training School, Lawrence and Memorial Associated Hospitals, 291.
- New Orleans, La. Child Welfare Association, 304.
- New York Association for Improving the Condition of the Poor, 342.
- New York City:
- American Nurses' Association, 335.
 - Argonne Association of America, 335.
 - Association for Improving the Conditions of the Poor, 342.
 - Babies' Hospital of the City of New York, 335.
 - Bureau of Educational Experiments, 336.
 - Children's Welfare Federation, 336.
 - Diet Kitchen Association, 343.
 - East Harlem Nursing and Health Demonstration, 337.
 - Federation for Child Study, Summer Play School, 337.
 - Henry Street Visiting Nurse Service, 338.
 - Hospital Social Service Association of New York City, Inc., 338.
 - Jewish Board of Guardians, 338.
 - Judson Health Center, 330.
 - Maternity Center Association, 339.
 - Mulberry Community House, 340.
 - National Child Labor Committee, 340.
 - National Child Welfare Association, 341.
 - National Federation of Day Nurseries, 341.
 - National League of Nursing Education, 341.
 - National Tuberculosis Association, 342.
 - Nursery and Child's Hospital, Social Service Department, 344.
 - State Charities Aid Association, 344.
 - New York Diet Kitchen Association, 343.
 - New York Nursery and Child's Hospital, Social Service Department, New York City, 344.
- New York State Department of Health, Division of Maternity, Infancy and Child Hygiene, Albany, N. Y., 331.
- Norfolk, Va. City Union of the King's Daughters, Visiting Nurse Service Clinic for Children, 377.
- Norwich, Conn. Connecticut Organization for Public Health Nursing, 291.
- Nursery schools. Lila Skinner, 210-14.
- Discussion:
- Richardson, Anna E., 214.
 - Ewing, William C., 214-15.
 - Sortor, Miss, 215.

- Nurses' section. Training leaders for child health work. Group discussion, 55-65.
- Discussion:
Place, Sara, 63-64.
Bryan, Mrs. Edith, 64.
Mulcahy, Charlotte, 64.
Faverley, Helen, 64-65.
- Nursing:
Atlanta, Ga., 294.
Berwick, Pa., 361.
Buffalo, N. Y., 333.
Cleveland, Ohio, 354.
Columbus, Ohio, 356.
Elkhart, Ind., 298.
Falmouth, Mass., 313.
Honolulu, Hawaii, 380.
Indianapolis, Ind., 300.
Louisville, Ky., 304.
Middletown, Conn., 288.
New Haven, Conn., 288.
New York, N. Y., 338.
Norwich, Conn., 291.
Oklahoma City, Okla., 358.
Pittsburgh, Pa., 368.
Providence, R. I., 373.
St. Louis, Mo., 324.
Toledo, Ohio, 357.
Wichita, Kan., 303.
Worcester, Mass., 315.
- Nursing, *see* also Visiting nurse associations.
- Nutrition Clinics, Cleveland, Ohio, 352.
- Oakland, Calif.:
Alameda County Tuberculosis, 279.
Public Health Center of Alameda County, 280.
- O'Brien, William A., M.D., and Adair, Fred L., M.D. Causes and prevention of antenatal, intranatal, postnatal, and neonatal deaths, 253-62.
- Obstetrics. Joint session on pediatrics and obstetrics of A. C. H. A. with Kansas City Clinical Society, 251-75.
- Office of the Public Welfare Commissioner, Manila, P. I., 381.
- Ohio State Association of Graduate Nurses, Columbus, Ohio, 356.
- Oklahoma City, Okla.:
Public Health Nursing Association, 358.
Public Health Association, 358.
Tuberculosis Society of Oklahoma City, 358.
- Omaha, Neb. Visiting Nurse Association, 326.
- Orange, N. J. Diet Kitchen of the Oranges, 380.
- Palama Settlement, District Nursing Department, Honolulu, Hawaii, 380.
- Palmer, George T., Dr. P. H. Preliminary report on a survey of child health activities in eighty-six cities, 173-78.
- Parents and Teachers Associations:
Boston, Mass., 374.
National Congress of, Washington, D. C., 293.
Rhode Island, Branch of the National, 374.
- Patchogue, N. Y. Suffolk County Tuberculosis Committee, 345.
- Pediatrics and obstetrics. Joint session of A. C. H. A. with Kansas City Clinical Society, 251-75.
- Peterson, Dora J., R.N. Training leaders for child health work. Rural work, 57-60.
- Philadelphia, Pa.:
The Babies' Hospital of Philadelphia, 362.
- Philadelphia, Pa.: (*Continued*)
The Children's Hospital, Department for the Prevention of Disease, 363.
Community Health Center, 363.
Association of Day Nurseries, 363.
Child Health Society, 364.
Health Council and Tuberculosis Committee, 365.
Pediatric Society, 365.
Preston Retreat Social Service, 365.
Public Charities Association of Pennsylvania, 366.
St. Christopher's Hospital for Children, Social Service Department, 366.
Starr Center Association, 367.
The Visiting Nurse Society of, 367.
The White-Williams Foundation, 367.
- Philippine Islands:
Office of the Public Welfare Commissioner, Manila, 381.
Philippines Chapter of the American Red Cross, Manila, 382.
- Phillips, Mr. Discussion, 80.
- Physical aspects of early adolescence. Borden S. Veeder, M.D., 111-16.
- Physicians in a community child health program. Essentials of preparation for. Clifford G. Grulee, M.D., 38-40.
- Pittsburgh, Pa.:
Chapter, American Red Cross, 368.
District Dairy Council, 368.
Public Health Nursing Association, 368.
County Service, 369.
Tuberculosis League of, 369.
Woods Run Settlement Day Nursery, 369.
- Place, Sara. Discussion, 63-64.
- Plainfield, N. J. Visiting Nurse Association of Plainfield and North Plainfield, 321.
- Poland. Medical Department of the Polish American Children's Relief Committee, Warsaw, 380.
- Portland, Me. Baby Hygiene and Child Welfare Association, 306.
- Portland, Ore.:
Bureau of Child Hygiene, State Board of Health, 350.
Visiting Nurse Association, 360.
- Prague, Czechoslovakia. Czechoslovakia Red Cross, 388.
- Preble County Board of Health, Eaton, Ohio, 357.
- Preschool children. Rural health supervision of babies and younger children. Florence L. McKay, M.D., 221-25.
- Preschool study for mothers. Mary H. Weeks, 226-28.
- Presidential message. Herbert Hoover, 3.
- Preston Retreat Social Service, Philadelphia, Pa., 365.
- Program for 1925, 30-32.
- Progress in child health—second annual report. Courtenay Dinwiddie, 8-33.
- Protestant Orphan Asylum, Cleveland, Ohio, 352.
- Providence:
Child Welfare Division, Rhode Island State Board of Health, 372.
Child Welfare Committee, 372.
Department of Health, Division of Child Hygiene, 372.
District Nursing Association, 373.
Rhode Island Branch of the National Congress of Parents and Teachers, Child Welfare Department, 374.
- Public Charities Association of Pennsylvania, 366.
- Public Health Center:
Alameda County, 280.
Brown County, Aberdeen, S. D., 375.

- Public Health, Department of. Edmonton, Alta., Canada, 383.
- Public Health Federation, Cincinnati, Ohio, 348.
- Public Health League, Seattle, Wash., 378.
- Public health nurses in relation to the child health program, Essentials of preparation for. Sophie C. Nelson, R.N., 45-47.
- Public health nursing, rural, 57-60.
- Public Health Nursing Association:
Indianapolis, Ind., 300.
Louisville, Ky., 304.
Oklahoma City, 358.
Pittsburgh, Pa., 368.
Wichita, Kan., 303.
- Public Health Nursing Bureau, Red Cross, Elkhart, Ind., 298.
- Public Health Nursing District, Western Reserve University, Cleveland, Ohio, 354.
- Public Health Nursing Service, Victoria, B. C., Canada., 383.
- Public health program. Session. E. H. Lindley, Presiding, 95-108.
- Racine, Wisc. Health Department, 379.
- Rankin, J. O. Discussion, 73.
- Ravenel, Mazyck P., M.D. Presiding. Training leaders for child health work. Session, 37-54.
- Reading, Pa. Visiting Nurse Association, 370.
- Red Cross:
American:
Greater Berwick Chapter, Berwick, Pa., 361.
Philippines Chapter, Manila, 382.
Pittsburgh Chapter, Pa., 368.
Public Health Nursing Bureau, Elkhart, Ind., 298.
Teaching Center, Cleveland, Ohio, 355.
Foreign:
Czechoslovakia Red Cross, Prague, 388.
Red Cross Public Health Nursing Bureau, 298.
Red Cross Teaching Center, Cleveland, Ohio, 355.
Reno, Nev. Child Welfare Division of State Board of Health, 327.
- Reports:
Affiliated societies, 277-390.
Executive committee, 6-7.
Financial report, 7.
General executive, 8-33.
- Rhode Island Branch of the National Congress of Parents and Teachers, Child Welfare Department, 374.
- Richardson, Anna E., Ph.D. Discussion, 89, 214.
- Richmond, Va. Virginia State Board of Health, Child Welfare Bureau, 377.
- Roche, Mary Margaret, R.N. Work for babies and younger children. Clinics or conferences, 206-9.
Discussion, 209.
- Rochester, N. Y.:
General Hospital and Dispensary, 346.
Tuberculosis and Public Health Association of Rochester and Monroe County, 346.
- Rood, Elma, R.N. Preparation of the teacher, 90-94.
Discussion, 93-94, 243, 244.
- Root, Aida de Acosta. May Day for child health, 190-194.
Discussion:
Ewing, William C., 194.
Root, Aida de Acosta, 194.
- Rural community organizers in child health work, Preparation and training. Florence Brown Sherbon, 69-72.
- Discussion:
Blackmar, F. W., Ph.D., 72-73.
Rankin, J. O., 73.
- Rural health supervision of babies and younger children. Florence L. McKay, M.D., 221-25.
- Discussion:
Koenig, Margaret, M.D., 225.
- Rural work. Training leaders for child health work. Nurses' section. Dora J. Peterson, R.N., 57-60.
- Rutherford County (Tenn.) Demonstration, 29-30.
- St. Christopher's Hospital for Children, Social Service Department, Philadelphia, Pa., 366.
- St. Louis, Mo.:
Children's Aid Society, 325.
Maternity Hospital, 325.
Missouri State Nurses' Association, 324.
Municipal Visiting Nurses, 324.
Pediatric Society, 326.
Visiting Nurse Association, 326.
- St. Paul, Minn.:
Division of Hygiene, Department of Education, 321.
Baby Welfare Association, 322.
- Salvation Army Rescue Maternity Hospital and Nursery Cleveland, Ohio, 355.
- San Francisco, Calif.:
Baby Hygiene Committee, Bay Branch of the American Association of University Women, 280.
Bureau of Child Hygiene, California State Board of Health, 281.
California Dairy Council, 281.
- Santa Barbara, Calif. Visiting Nurse Association, 282.
- School medical inspection, Organization of. Harold H. Mitchell, M.D., 233-37.
- School nursing, Organization of. Elmira W. Bears, R.N., 238-40.
- School of Public Health Nursing, Iowa City, Ia., 302.
- Schools, What they should do for health of children. Thomas D. Wood, M.D., 231-32.
- Schwab, Sidney I., M.D. Problems of late childhood and adolescence—mental aspects, 117-25.
- Schweitzer, Ada E., M.D. Discussion, 79-80.
- Scottish Rite Infant Welfare Department, Duluth, Minn., 318.
- Seattle, Wash.:
Division of Child Hygiene, State Department of Health, 378.
Public Health League of Washington, 378.
- Shanghai, China. Council on Health Education, 389.
- Sherbon, Florence Brown, M.D. Preparation and training of rural community organizers in child health work, 69-72.
- Shonka, Rose. Relation of home economics department to class-room teacher, 241-43.
Discussion, 245.
- Sinclair, John F., M.D. Discussion, 79, 209.
- Skinner, Lila. Nursery schools, 210-14.
- Smith, Barry C. Essentials of community organization for child health work, 139-41.
- Smith, Barry C. Presiding. Essentials of community organization for child health work. Session, 137-67.
- Smith, Richard M., M.D. Clinical aspects of tuberculosis in infants, 263-69.
Discussion, 53-54.

- Snow, Dr. Discussion, 248.
 Society of the Home of the Holy Family, Cleveland, Ohio, 355.
 Sortor, Miss. Discussion, 215.
 South Bend, Ind. Children's Dispensary and Hospital Association, 301.
 Springfield, Mass. Visiting Nurse Association, 315.
 Stanley, Louise, Ph.D. Contribution of the home demonstration agent to health supervision and education for mothers, babies, and younger children in rural communities, 216-20.
 Starr Center Association, Philadelphia, Pa., 367.
 State Association of Graduate Nurses, Atlanta, Ga., 294.
 State Board of Charities, Albany, N. Y., 332.
 State Charities Aid Association, New York City, 344.
 State Department of Public Health, Division of Maternal and Infant Hygiene, Nashville, Tenn., 375.
 Stillbirths, 258-59.
 Strachan, Louise. Discussion, 94.
 Suffolk County Tuberculosis Committee, Patchogue, N. Y., 345.
 Survey of eighty-six cities, Practical application of the findings of. Samuel J. Crumline, M.D., 179-82.
 Preliminary report on. G. T. Palmer, Dr. P. H., 173-78.
 Swarthmore Chautauqua Association, Swarthmore, Pa., 370.
 Sykes, Mildred. Teaching health through nature study, 85-88.
- Teacher, Preparation of the. Elma Rood, R.N., 90-93.
 Discussion:
 Dolfinger, Emma, 93-94.
 Rood, Elma, R.N., 93-94.
 Strachan, Louise, 94.
 Teachers' section. Training leaders for child health work. Group discussion, 83-94.
 Thomas H. Swope Settlement, Kansas City, Mo., 324.
 Thomson, Elnora, R.N. Conditions in the Far West, 188-89.
 Thomson, Elnora, R.N., presiding. Essentials of community organization for child health work. Section 1, 195-228.
- Toledo, Ohio:
 Dental Dispensary Association, 357.
 District Nurse Association, 357.
- Toronto, Ont., Canada. Department of Public Health, Child Hygiene Section, 385.
- Training leaders for child health work. Section, 35-94.
 Discussion:
 Smith, Richard M., M.D., 53-54.
 Wood, Thomas D., M.D., 54.
 Session. Group discussion, 55-94.
 Nurses' section, 55-65.
 Community organizers' section, 67-81.
 Teachers' section, 83-94.
- Tuberculosis Associations:
 1. State:
 Colorado, Denver, 284.
 Iowa, Des Moines, 301.
 Massachusetts, League, Boston, 311.
 New York, National, New York City, 342.
 2. City:
 Cincinnati, Ohio, 348.
 Denver, Colo., 283.
 Erie, Pa., 362.
- Tuberculosis Association: 2. City:
 (Continued)
 Oklahoma City, Okla., 358.
 Philadelphia, Pa., Health Council and, 365.
 Pittsburgh, Pa., 369.
 Rochester, N. Y., 346.
3. County:
 Alameda, Calif., Oakland, 279.
 Hudson, Jersey City, N. J., 329.
 Monroe, N. Y., Rochester and, 346.
 Suffolk, Patchogue, N. Y., 345.
- Tuberculosis and Public Health Association of Rochester and Monroe County, Rochester, N. Y., 346.
- Tuberculosis in infants, clinical aspects. Richard M. Smith, M.D., 263-69.
- Tulsa (Okla.) County Public Health Association, 359.
- Turner, C. E. Essentials of preparation for health educators in a community child health program, 41-44.
 Report on the health education conference at the Massachusetts Institute of Technology, 183-87.
- Urology, Recent clinical studies in. Guy L. Hunner, M.D., 270-75.
- Utica, N. Y. Baby Welfare Committee of Utica, 347.
- Veech, Annie S., M.D. Joint responsibility of public and private agencies and obligations of community in observation of child health program, 162-64.
- Veeder, Borden S., M.D. Physical aspects of early adolescence, 111-18.
- Victoria, B. C., Canada. Public Health Nursing Service, 388.
- Vincent, George E., Ph.D. Doctor of the future, 97-101.
- Virginia State Board of Health, Child Welfare Bureau, Richmond, Va., 377.
- Visiting Nurse Associations:
 Bridgeport, Conn., 286.
 Brooklyn, N. Y., 333.
 Canada, Victoria, B. C., 383.
 Cleveland, Ohio, 356.
 Denver, Colo., 285.
 Fitchburg, Mass., 313.
 Jamestown, N. Y., 334.
 Kansas City, Mo., 324.
 Minneapolis, Minn., 321.
 New Bedford, Mass., 314.
 New Haven, Conn., 289.
 New York, N. Y., 338.
 Norfolk, Va., 377.
 Omaha, Neb., 326.
 Philadelphia, Pa., 367.
 Plainfield, N. J., 331.
 Portland, Ore., 360.
 Reading, Pa., 370.
 St. Louis, Mo., 324.
 Santa Barbara, Calif., 282.
 Springfield, Mass., 315.
 Waterbury, Conn., 291.
 Wilkes-Barre, Pa., 371.
 York, Pa., 371.
- Visiting Nurse Association, *see also* Nursing.
- Ward IV Infant Welfare Committee of Cambridge, Mass., 312.
- Warsaw, Poland. Medical Department of the Polish-American Children's Relief Committee, 389.
- Washington, D. C.:
 Health Department, Child Hygiene Service, 293.

- Washington, D. C.: (*Continued*)
National Congress of Parents and Teachers, 293.
- Waterbury, Conn. Visiting Nurse Association, 291.
- Weeks, Mary H. Preschool study for mothers, 226-28.
- White-Williams Foundation, Philadelphia, Pa., 367.
- Whitson, Walter. Discussion, 171.
- Wichita, Kan. Public Health Nursing Association, 303.
- Wilkes-Barre, Pa. Visiting Nurse Association, 371.
- Wilson, Mr. Discussion, 135.
- Woman's Club, Chicago, Ill., 296.
- Wood, Thomas D., M.D. Opening address. Convention, 4-5.
What schools should do for the health of children, 231-32.
- Wood, Thomas D., M.D., presiding. Essentials of community organization for child health work. Section 2. Health work in the schools, 229-46.
Discussion, 54, 243, 244-45.
- Woods Run Settlement Day Nursery, Pittsburgh, Pa., 369.
- Worcester, Mass. Society for District Nursing, 315.
- Yale Psycho-Clinic, New Haven, Conn., 290.
- York, Pa. Visiting Nurse Association, 371.

